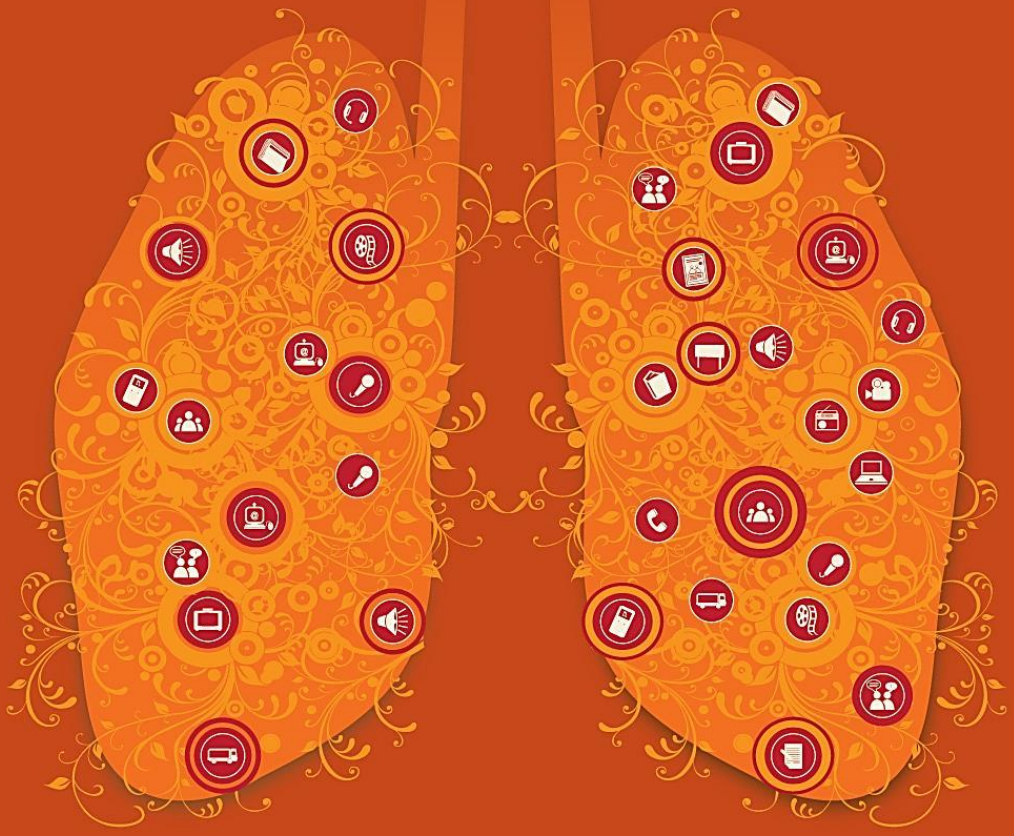
TB MONOGRAPH

Ministry of Health
and Family Welfare
Government of India

सत्यमेव जयते

NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

Social and Behavior Change Communication for Tuberculosis Control: Good Practices from Around the Globe



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List of Acronyms

ACSM	Advocacy, Communication, and Social Mobilization
AIHA	American International Health Alliance
ASHA	Accredited Social Health Activist
AW	Anganwadi Worker
BCC	Behavior Change Communication
BHW	Barangay Health Workers
BTBP	Barangay TB Patrol
CBO	Community-based Organization
CSO	Civil Society Organization
CTD	Central TB Division (Government of India)
DANTB	Danish Assistance to the Revised National TB Control Programme of India
DOT	Directly Observed Treatment
DOTS	Directly Observed Treatment, Short Course
DP	DOT Providers
FP/RP	Family Planning/Reproductive Health
GOI	Government of India
IDU	Injection Drug Users
IEC	Information, Education and Communication
IHBP	Improving Healthy Behaviors Program
IPC	Interpersonal Communication
IPC/C	Interpersonal Communication and Counseling
JHU–CCP	Johns Hopkins University Center for Communication Programs
KAP	Knowledge, Attitudes, and Practices
MC	Microscopy Center
MCH	Maternal Child Health
NGO	Nongovernmental Organization
NLDP	Non- or Neo-Literate DOT Providers
NTP	National Tuberculosis Program
NTCP	National TB Control Program
PIM	Participation, Interaction, and Mobilization
PLHIV	People Living with HIV
PSA	Public Service Announcement
RNTCP	Revised National Tuberculosis Control Program (of India)
SBCC	Social and Behavior Change Communication
SCC	Sputum Collection Center
SHG	Self-Help Group
SIDA	Swedish International Development Agency
SM	Social Mobilization

SOLUCION TB	Strengthening Observed therapy Linking Up Community-based Integrated Outreach Networks for TB control
STS	Senior Treatment Supervisor
TAS	Tribal Area Supervisor
TB	Tuberculosis
USAID	United States Agency for International Development
WHO	World Health Organization

I. Executive Summary

Tuberculosis (TB) management has been a long-standing challenge with concentrated government efforts to manage TB in India since about 1906. India accounts for 26 percent of the global TB cases, with more than 1.4 million TB case diagnosed in 2012 alone. Based on guidelines for directly observed treatment (DOTS), the Ministry of Health and Family Welfare launched the Revised National TB Control Program (RNTCP) in 1997. In 2005, the Central TB Division (CTD) approved a national health communication strategy to increase TB awareness, diagnosis and services and later revised it to align with the global Advocacy, Communication, and Social Mobilization (ACSM) initiative and change behaviors related to case detection and treatment adherence. An evaluation of a U.S. Agency for International Development (USAID)-funded program that supported RNTCP health communication from 2008–2009[1] showed that the implementation of ACSM activities beyond capacity building has been fairly limited. Some states have implemented social and behavior change communication (SBCC) activities as part of their ACSM efforts, but these have not been coordinated under the national campaign.

The FHI 360 USAID/India-funded task order for the Improving Healthy Behaviors Program (IHBP) improves adoption of healthy behaviors through national-, state-, and district-level institutional and human resource capacity building. IHBP commissioned a review of good practices in SBCC/ASCM for TB control to help SBCC specialists and program managers design and implement effective communication programs. The authors initially reviewed literature to identify successful SBCC interventions in India and neighboring South Asian countries, but subsequently expanded the review to other geographic regions to garner a greater variety of examples.

The review yielded 15 case studies in which ACSM was either the primary or secondary focus of the intervention, supporting TB case detection and treatment. Many of the interventions highlighted in this document focused on community-based education, provider interpersonal communication and counseling (IPC/C), and expanding access to health services. Mass media interventions were not as common for TB but addressed other health issues. Several projects highlighted also featured advocacy as a key strategy for making TB a higher government priority for increasing access to TB services.

Case studies in this review used at least two of the following good practices in ACSM for TB control:

- **Social mobilization (SM) to expand case detection and diagnosis** by recruiting community volunteers or community health workers to serve as TB screeners and staff at sputum collection and diagnostic centers

- **SM to improve or expand treatment** by recruiting community volunteers or community health workers to be DOTS providers in underserved rural and urban slum areas

- **Addressed stigma** by giving TB patients a voice in their communities by addressing stigma in mass media campaigns, creating TB clubs, training former TB patients to counsel current patients, involving TB patients in advocacy activities, and organizing exhibits featuring the photos and stories of those affected by TB

[1] Evaluation of Tuberculosis Program in India. PATH Report. De Muync, A. et al. March 2011. http://pdf.usaid.gov/pdf_docs/PDACR865.pdf

- **Robust research** to evaluate, monitor, or inform the development of their programs; conducted pre/post knowledge, attitudes, and practices (KAP) surveys and intervention/control studies to evaluate the impact of their program

- **Strong or innovative partnerships** with community groups, religious leaders, pharmaceutical companies, and private health care providers

- **Extensive provider training and/or support,** training for large numbers of community health care providers to identify and treat TB patients, and then providing them with supportive supervision; also strengthened the IPC/C skills of large numbers of health care providers in the formal health system

- **Innovative community channels** to increase awareness of TB and identify new cases, such as self-help groups (SHGs), traditional healers, religious institutions, and photography exhibitions

- **Strong communication planning,** developing ACSM strategies, focusing efforts on the most vulnerable populations or the lowest performing areas, and creating tailored messages and materials for different audiences

- **Focused on sustainability** by integrating TB activities within existing programs and advocating for political and financial support for TB services from local and national governments; built the ACSM capacity of local nongovernmental organizations (NGOs), to sustain activities

- **Participatory processes** to design and implement interventions, thereby promoting community ownership of the programs

- **Adapted materials to local context** by translating them into local language, adjusting them for urban versus rural contexts, and using illustrations to convey complex concepts for low-literacy DOTS providers

- **Strong linkages** between the media and local health systems or the community and local health systems by educating health staff on the unique culture of tribal populations, enhancing coordination between these groups, training journalists on TB issues, and creating referral chains between community-based providers/groups and TB services

- I**nnovative technology**, such as an interactive mobile phone app for screening potential TB patients, mobile phones for paying incentives to doctors and TB treatment completers, video conferencing for distance education, and cameras for TB patients to document their own stories

The findings of this review will inform the development of evidence-based SBCC/ACSM strategies and programs to improve the quantity and quality of TB services in India, as well as reduce stigma.

II. Introduction and Methodology

A. Tuberculosis in India

Tuberculosis (TB) management has been a long-standing challenge with concentrated government efforts to manage TB in India since about 1906. India accounts for 26 percent of the global TB cases, with more than 1.4 million TB cases diagnosed in 2012 alone. Although TB prevalence and mortality have decreased since 1990, it is still estimated that 40 percent of the country's population is infected with TB bacteria.[2]

In 1992, the Government of India (GOI), the Swedish International Development Agency (SIDA), and the World Health Organization (WHO) conducted a review of the National TB Program (NTP) and found that it needed revamping across several areas: insufficient funding, poor management, and low rates of treatment completion. As a result, the GOI revised the national TB strategy and developed the Revised National Tuberculosis Control Program (RNTCP). Based on directly observed treatment (DOTS) guidelines, the Ministry of Health and Family Welfare launched the RNTCP nationally in 1997. The first phase of the RNTCP ran from 1998–2005 and concentrated on the expansion of DOTS services nationally; by 2006, the entire country was covered by DOTS. The second phase of the program (through 2015) focuses on the implementation of the Stop TB Strategy to increase the scope for providing standardized, quality treatment and services in a patient-friendly environment.[3] The new vision of RNTCP in its National Strategic Plan (2007–2015) aims to achieve "universal access" for quality diagnosis and treatment for all TB patients in the community. This requires sustaining the achievements of the program to date, and extending the reach and quality of services to all persons diagnosed with TB.[4]

Although the RNTCP provides free care, more than half of TB patients seek care in private facilities or go untreated[5] for several reasons: low awareness of services through the RNTCP, convenience of services, and desire for confidential and personalized services.[6] RNTCP efforts need to be expanded to involve the private sector and provide them with standard guidelines of TB care.

In 2005, the Central TB Division (CTD) approved a national health communication strategy to increase TB awareness, diagnosis, and services. The strategy's approach used community education and patient-provider interpersonal communication (IPC). It was later revised to align with the global Advocacy, Communication and Social Mobilization (ACSM) initiative and change behaviors related to case detection and treatment adherence. The strategy also aimed to build political, administrative, and community-level support for TB control. The CTD supports states and districts with resources and technical assistance. States and districts are then responsible for integrating ACSM activities into work plans. An evaluation of a USAID-funded program that supported RNTCP health communication efforts from 2008–2009 showed that the implementation of ACSM activities beyond capacity building has been

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[2] TB Facts.org. Accessed October 28, 2013. http://www.tbfacts.org/tb-india.html

[3] TBC India, Directorate General of Health Services, Ministry of Health and Family Welfare. National TB Control Website Accessed October 17, 2013 at http://www.tbcindia.nic.in/.

[4] *Universal access to TB care – A practical guide for programme managers*. Directorate General of Health Services, Ministry of Health and Family Welfare. Accessed February 24, 2014 at http://www.tbcindia.nic.in/pdfs/Universal_accessto_TB_Care.pdf

[5] Revised National Tuberculosis Control Program in India: The Need to Strengthen. *International Journal of Preventive Medicine*. Verma, M. et al. January 2013; 4(1): 1–5.

[6] TB Facts.org. Accessed October 28, 2013 at http://www.tbfacts.org/tb-india.html

fairly limited.[7] There has also been a disconnect between strategies developed at the national level and implementation at the district level. The objective and components of the national health communication strategy are not reflected in the state and district information, education, and communication (IEC) action plans and require needs-based planning for ACSM activities. Although there is a state-level ACSM plan, district planning for ACSM remains weak, where such plans are synonymous with IEC plans.[8] Implementation focused more on communication activities and less in advocacy and SM components.

Various states have carried out IEC campaigns but not coordinated under one national campaign. Further, the IEC activities have focused on products and not the communication process.[9] Health communication materials, including print materials, have been developed and translated in 17 languages, but these have lacked clear content and audience-specific focus. For instance many materials have been text-based and not appropriate for audiences with lower literacy.[10] [11] Literacy has been shown to be a factor in low levels of TB awareness.[12] Low awareness around TB transmission may be due to lack of effective IEC materials.

The Joint Monitoring Mission 2012 report stated that, "Systematic involvement of civil society organizations (CSOs) is limited, although there are a few instances in which self-help groups (SHGs), Panchayati Raj institutions, cooperatives, the youth, CBOs, faith leaders, etc. have been involved. Not much emphasis is placed on community-based monitoring and patient-centered approaches, such as interpersonal communication (IPC) and counselling." [13]

Under the Global Fund Round 9, The Union and World Vision are leading focused ACSM activities in 374 districts of the country. The project, however, needs more coordination with the RNTCP program at state and district levels. In addition, there are limitations to geographic coverage and the frequency of the activities carried out under it.[14] Although partners are using participatory and innovative methods in various parts of the country, there is still a need for these lessons learned to be shared through the RNTCP.[15]

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[7] *Evaluation of Tuberculosis Program in India*. PATH Report. De Muync, A. et al. March 2011. http://pdf.usaid.gov/pdf_docs/PDACR865.pdf

[8] Joint Monitoring Mission report, RNTCP India 2012.

[9] Joint Monitoring Mission report, RNTCP India 2009, accessed on February 24, 2014, http://tbcindia.nic.in/Pdfs/JMM-Report-2009.pdf

[10] Level of awareness about tuberculosis in urban slums: Implications for advocacy and communication strategy planning in the National program. Chinnakali, P. et al. *Lung India*. 2013 Apr;30(2):139-42. doi: 10.4103/0970-2113.110422. PubMed PMID: 23741095.

[11] The impact of an IEC campaign on tuberculosis awareness and health seeking behaviour in Delhi, India. *International Journal of Tuberculosis Lung Disease*. Sharma, N. et al. 2005. 9(11):1259–1265.

[12] Level of awareness about tuberculosis in urban slums: Implications for advocacy and communication strategy planning in the National program. Chinnakali, P. et al. *Lung India*. 2013 Apr;30(2):139-42. doi: 10.4103/0970-2113.110422. PubMed PMID: 23741095.

[13] Joint Monitoring Mission report, RNTCP India 2012.

[14] Joint Monitoring Mission report, RNTCP India 2012.

[15] *Reducing TB Cases in India*. Eli Lilly and Children International's Teen Campaign. October 5, 2010. http://www.disabled-world.com/news/asia/india/tb-india.php

B. Improving Healthy Behaviors Program

The FHI 360 USAID/India-funded task order for IHBP aims to improve adoption of healthy behaviors through institutional and human resource capacity building of national-, state-, and district-level institutions to design, deliver and evaluate communication programs that will:

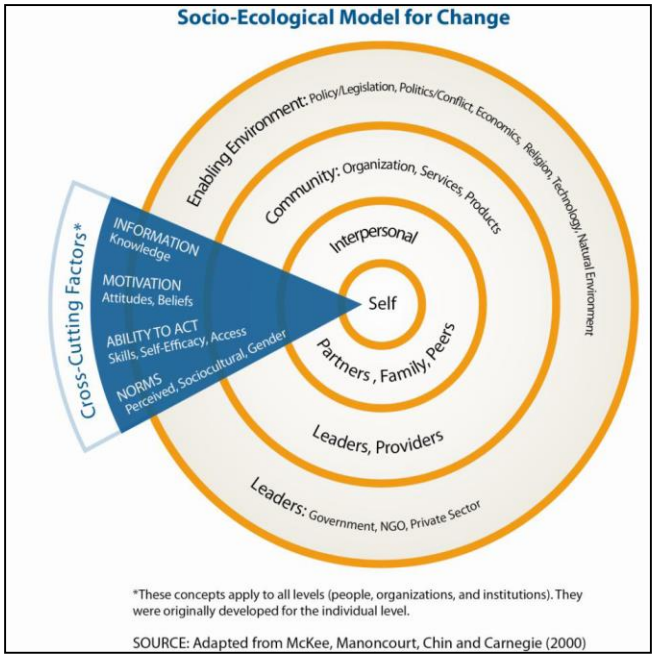
- Increase knowledge and change attitudes and behaviors of individuals, families, communities, and health providers about health.
- Promote an environment where communities and key influencers promote and support positive health behaviors.
- Reduce barriers of vulnerable populations (women, people living with HIV [PLHIV], TB patients) to demand and access health services.

The project focuses on four technical areas: HIV/AIDS, family planning and reproductive health (FP/RH), tuberculosis (TB), and maternal and child health (MCH). One of the program's key components is social and behavior change communication (SBCC).

C. Overview of Social and Behavior Change Communication

SBCC is an interactive, theory-based, and research-driven communication process and strategy to address change at individual, community, and societal levels.[16] It is a process, uses a socio-ecological model for change, and operates through three strategies:

- **Advocacy** to raise resources and political/social leadership commitment for development actions and goals
- **Social mobilization (SM)** for wider participation, coalition building, and ownership, including community mobilization
- **Behavior change communication (BCC)** for changes in knowledge, attitudes, and practices of specific participants/audiences in programs



SBCC applies a socio-ecological model[17] that examines several levels of influence to provide insight on the causes of problems and to find the ***tipping point*** for change—the point at which a behavioral practice spreads suddenly within and across populations.[18] This model is a combination of ecological models and sociological and psychological

[16] *C-Modules. A Learning Package for Social and Behavior Change Communication. Module 0 Practitioner's Handbook.* C-Change Project. http://www.fhi360.org/resource/c-modules-learning-package-social-and-behavior-change-communication. Accessed March 4, 2014.

[17] Ibid.

[18] *Leadership and Communication: Lessons from The Tipping Point*. Ward, T. et al. Cambridge Center for Behavioral Studies, Inc. 2011. http://www.behavior.org/resources/503.pdf.

factors and layers of influence that can assist program managers in analysis and planning.

Effective SBCC programs apply a set of core principles:

- **Principle #1:** Follow a systematic approach.
- **Principle #2:** Use research (for example, operational), not assumptions, to drive programs.
- **Principle #3:** Consider the social context.
- **Principle #4:** Keep the focus on the key audience(s)/populations.
- **Principle #5:** Use theories and models to guide decisions.
- **Principle #6:** Involve partners and communities throughout.
- **Principle #7:** Set realistic objectives and consider cost effectiveness.
- **Principle #8:** Use mutually reinforcing materials and activities at many levels.
- **Principle #9:** Choose strategies that are motivational and action-oriented.
- **Principle #10:** Ensure quality at every step.

These principles can serve as a compass, helping managers and SBCC specialists to plan their programs and stay on track during implementation and evaluation. Many of the good practices described in this document tie into to the 10 principles outlined above.

In the TB control arena, SBCC is often referred to as **ASCM—advocacy, communication, and social mobilization.** TB has traditionally been controlled through a vertical and medical health service delivery model. The incorporation of ACSM into national TB programs is relatively recent. According to the Stop TB Partnership, ACSM can contribute to TB control by:[19]

- Improving case detection and treatment adherence.
- Combating stigma and discrimination.
- Empowering people affected by TB.
- Mobilizing political commitment and resources for TB.

Patient and community empowerment are important components of ACSM in the TB control arena, as several of the case studies in this document demonstrate. Although mass media can raise awareness of TB symptoms and transmission routes, community-level partnerships are critical for success—to combat stigma, detect new TB cases, and support those who must undergo treatment. Success also hinges on having support from the highest levels of government to ensure widespread availability of clinical services.

D. Purpose of Document and Methodology

IHBP commissioned a review of good practices in SBCC/ASCM for TB control to help SBCC specialists and program managers design and implement effective communication programs. The authors initially reviewed published and unpublished literature to identify successful SBCC interventions in India and neighboring South Asian countries—Sri Lanka, Nepal, Bangladesh, and Pakistan.

[19] *Advocacy, Communication, and Social Mobilization to Fight TB: A 10 Year Framework for Action*. World Health Organization and the Stop TB Partnership. Accessed on March 4, 2013 at http://www.stoptb.org/assets/documents/countries/acsm/TB_ADVOCACY_ISBN.pdf

The literature review included two levels of analysis. The first level involved conducting a search for good practices in the past 10 years through popular search engines and databases in addition to specific publishing houses for TB SBCC/ACSM as main themes. Sub-themes for TB included:

- Stigma and discrimination
- Spousal support
- Early detection
- Dose compliance

The first level of literature review yielded a list of 43 interventions in TB that could be studied further for potentially good practices and lessons in health communication. The second level of analysis involved shortlisting the case studies by eliminating those that only had a clinical focus—that is, they only dealt with improving the clinical detection and/or treatment of TB. To be shortlisted, case studies had to describe the implementation of at least one aspect of ACSM—advocacy, communication, or social mobilization. Based on these criteria, only six interventions were shortlisted. For this reason, the review was expanded to include other geographic regions, including Southeast Asia, Latin America, and the former Soviet Union. An additional 8 case studies were identified, bringing the total number of shortlisted case studies to 15.

The section below describes the good SBCC/ACSM practices that were identified, with examples from selected case studies. The summary of good practices is followed by a matrix of case studies. Not all of the case studies will be relevant for all readers. ***Therefore, readers are invited to consult this matrix to identify the case studies that most closely match their own program needs, and then read those specific case studies to obtain detailed information about how these programs employed good SBCC practices.*** An index at the end of this document cross references all of the good practices by case study, for those readers who wish to consult those program examples that effectively demonstrate a particular good practice.

III. Good Practices and Case Studies

A. Good Practices

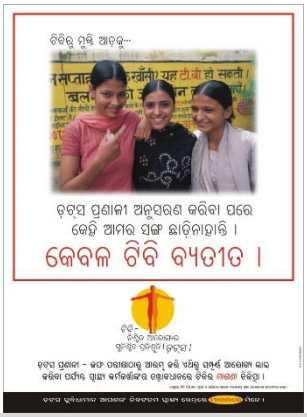
A wide range of good practices were identified in research, program implementation, and sustainability. Interventions that met the criteria for inclusion used at least two of the following practices:

- **Expanded case detection/diagnosis through social mobilization –** The Malkangiri Community DOTS TB project mobilized community volunteers and pharmacists to staff the new sputum collection centers (SCCs) in underserved tribal areas. BRAC and the Damien Foundation expanded community-based detection and diagnosis of TB cases by mobilizing lady volunteers, village doctors, and TB clubs. In Pakistan, the Stop TB Partnership trained community laypeople to use mobile phones equipped with a TB screening app to identify new TB cases at family clinics and hospital outpatient departments.

- **Improved/expanded treatment through social mobilization** – The Malkangiri Community DOTS TB project mobilized over 500 non- or neo-literate health volunteers to provide DOTS in tribal areas. BRAC and the Damien Foundation mobilized lady health volunteers and village doctors to provide DOTS in underserved, largely rural areas of Bangladesh. Operation Asha (the Hindi word for "hope") recruited slum dwellers and private health care staff to provide DOTS in New Delhi.

- **Addressed stigma** – Several projects, including BRAC and the Damien Foundation, helped to mitigate stigma by creating TB clubs that recruited former TB patients to detect new cases. The National TB Program in Vietnam organized a group of fully recovered patients who received training courses on TB knowledge and communication skills. Former patients then counseled current TB patients and also participated in TB advocacy meetings at the hospital and community level. The TB program in Moldova incorporated anti-stigma messages into its national mass media campaign. The Strengthening Observed therapy Linking Up Community-based Integrated Outreach Networks for TB control (SOLUCION TB) program in Mexico used photography and narratives of TB patients to humanize the disease and educate decision makers, health care providers, and the public at large on what TB means for those who are affected by it.

Malkangiri Community DOTS Project – India



Malkangiri is a district in Orisha State characterized by geographic inaccessibility, huge physical distances between sparsely populated villages, and large the social and cultural distances between the people and health providers. LEPRA India, with funding from the Danish Assistance to the RNTCP (DANTB), established a corps of community DOTS providers in remote tribal areas with low literacy rates and limited access to health care. This involved developing appropriate communication and training materials to equip the non- or neo-literate DOTS providers (NLDPs) to understand TB as a public health problem in their area, to generate awareness about it at local level, to help symptomatic people access microscopy services and to supervise treatment of identified cases based on the principles of DOTS. Over 500 NLDPs were trained. Tribal area supervisors (TAS) were identified to serve as a link between the government health system, community DOTS providers (DPs), and patients. The project also set up new SCCs and trained held "culture and communication" workshops to sensitize health system staff to the special needs of tribal patients. Project results included increased awareness of TB and its treatment among remote villagers, high appreciation for the TAS as a link between villagers and the health system, and high treatment adherence rates among patients treated by NLDPs.

- **Robust research** – Several projects conducted extensive formative research, such as the Vietnam national TB program, which did surveys in eight provinces to understand how people received information about TB. The national TB programs in Tajikistan and Moldova conducted pre- and post-KAP surveys to demonstrate positive changes in TB knowledge, attitudes and practices. Other programs conducted rigorous evaluations using intervention and control groups, such as the Stop TB Partnership program in Pakistan and the study to assess the effectiveness of involving religious leaders in TB case detection, also in Pakistan.

- **Strong/innovative partnerships** – In Bulacan province of The Philippines, different sectors of the community came together to create an anti-TB task force that supported case detection, treatment, and TB education. The Orisha ASCM project partnered with a wide range of NGOs to

provide SM activities that address specific TB needs; the project also greatly improved coordination between civil society and government TB services. The National TB Control Program in Peru worked to establish relationships with international and national partners and coordinated partner support. Special efforts were also made to engage and involve community-based organizations (CBOs), churches, pharmaceutical companies, and private practitioners.

- **Extensive provider training/support** – The ACSM project in Odisha strengthened the capacity of a wide variety of providers, including government DOTS providers, accredited social health activists (ASHAs), anganwadi workers (AWs), AYUSHA (alternative medicine) doctors, and traditional healers. Peru's national TB program strengthened the IPC/C skills of all government TB workers to increase TB knowledge and reduce deep-seated stigma. The Malkangiri Community DOTS TB project trained TASs to provide extensive, supportive supervision to NLDPs.

- **Innovative community channels** – The Odisha ACSM project engaged a large number of stakeholders not previously involved in TB control, such as self-help groups, local self-governing institutions, and traditional healers. BRAC and Damien Foundation and the Maguindanao TB Control Project organized TB clubs to engage former TB patients in identifying new TB cases. Operation Asha organized TB education events at temples, schools, and other community venues. SOLUCION TB and the project in Pakistan had religious leaders educate the community about TB in mosques and churches. SOLUCION TB also organized special community exhibits showcasing photos and narratives of people affected by TB to destigmatize the disease.

- **Strong communication planning** – Tajikistan drafted a national TB communication strategy. The public awareness campaign in Moldova developed a branded communication kit, including communication guides and tailored messages for different audiences, such as injecting drug users and PLHIV. The ACSM project in Odisha developed a state-specific ACSM strategy that included tailored messages to address specific TB problems in low performing areas.

- **Focus on sustainability** – The BRAC TB control program has earned high marks for sustainability because of its integration into existing health and micro-credit programs. The Vietnam project obtained support of local leaders by disseminating information, organizing steering committees, and sending them on study tours. The Maguindanao TB Control Project in the Philippines lobbied local government units to make TB prevention a priority and to allocate the needed resources to the project. The ACSM project in Odisha State built the capacity of local "interface" NGOs to deliver SM interventions, thereby increasing community ownership of activities. Operation Asha advocated with local politicians to secure support to establish community-managed DOT centers.

- **Participatory processes** – SOLUCION TB used Photovoice, a participatory methodology whereby TB patients record their own images and stories to catalyze change. The Maguindanao TB Control project involved health providers, patients, and community members in all stages of the intervention to ensure that all voices were heard throughout the process.

- **Adaptation of materials to local context** – The Malkangiri Community DOTS TB project developed a pictorial card to help NLDPs to track the treatment of TB patients. The National TB Program in Vietnam adapted print materials to the literacy and language needs of ethnic minorities, including H'Mong, Thai, Ede, Khmer, and Chinese. The National TB Program in Peru

made print materials available in local languages and adapted a counseling flipchart for urban and rural contexts.

- **Strong media/community/health system linkages** – In Peru, the brand and logo for government health services were promoted widely through mass media and community-based activities. Demand generation was carefully timed to coincide with government expansion of TB services for diagnosis and treatment. The ACSM project in Odisha enhanced coordination between NGOs implementing community-based activities and health staff at multiple levels. The BRAC and Damien Foundation programs used community-based DOTS providers to strengthen the linkages between communities and the formal health system.

Project AXSHYA – India

This project, implemented by the International Union Against Tuberculosis and Lung Disease (The Union) and supported by the Global Fund, implements ACSM activities through a national network of partner organizations. The AXSHYA project is complementing RNTCP efforts, engaging private providers in RNTCP schemes, improving access to diagnostics, committing to fight drug-resistant TB and TB-HIV at all levels, and enhancing civil society involvement in TB care and control. Project partners implement activities in 300 districts through their own sub-networks of NGOs and CBOs. One of the project's key activities has been the Bulgam Bhai, or "Mr. Sputum" mass media campaign to increase TB awareness. The campaign includes TV, radio, print ads, and IPC toolkits, games and street theater scripts. Mr. Sputum—who is a superhero—uses humor to remind people that they need to have their sputum tested if they have a cough for more than two weeks. The project has given current and past TB patients a voice by establishing more than 200 district-level TB forums. The project has also worked to empower TB patients by developing an illustrated version of the Patient Charter for TB Care, translating it into 19 languages, and disseminating it through TB forums and community meetings.

- **Innovative use of technology** – The Stop TB Partnership project in Pakistan used a mobile app to screen TB patients and send them monetary rewards for complying with treatment. The Strengthening TB Control Program in Moldova trained providers via video conferencing. The SOLUCION TB project in Mexico gave cameras to TB patients to help them record their experiences, forming the basis of "Photovoice" exhibits.

B. Innovations

The review highlighted several examples of practices that were innovative the time when these interventions were implemented. One example was the use of **pictorial TB treatment cards** that allowed non- or neo-literate community DOTS volunteers to successfully track the treatment of patients in isolated, tribal communities—proving that innovations do not have to be high tech. This same project hired **tribal area supervisors (TAS)** to supervise the DOTS volunteers. This was a new position that was highly effective in being a link between tribal communities and the health system.

In the Bulacan province of The Philippines, the government created an **anti-TB community task force**, composed of the local Catholic parish, women's groups, Rotary Club, local schools, *barangay* (village) volunteers, and health workers. This task force formulated TB health plans, educated TB suspects and patients, and supported TB case detection and treatment. BRAC, the Damien Foundation, and other projects organized current and former TB patients into **TB clubs**, with the dual objective of combating stigma and helping to identify new TB cases in their communities.

The Stop TB Partnership program in Pakistan used an **interactive mobile phone app** to screen potential TB patients. The project also sent **cash incentives via mobile phone** to reward screeners for finding new cases and reward doctors and patients for completing treatment. Mexico's National TB Program used the **Photovoice approach**, providing TB patients with cameras to document their stories and experiences, and then sharing the results through special community exhibitions. The Strengthening TB Control in Moldova program trained health providers via **videoconferencing**—one of the first examples of modern distance education in that country.

C. Case Studies

The following matrix summarizes the programs and interventions that met the criteria for inclusion in this document. They are organized into to two categories:

- **Programs with ACSM as the primary focus:** These programs had advocacy, communication, and social mobilization for TB control as their foundation. Many of them had multi-faceted communication campaigns and strong communication strategies and KAP evaluations.

- **Programs with TB diagnosis/treatment as the primary focus**: These programs were centered on increasing access to the identification, detection, and treatment of TB within communities. They all featured some type of ACSM activity, but it was a smaller part of the overall program.

The case studies are organized into these categories to facilitate navigation through the document. This grouping is not intended as a recommendation for whether TB programs should focus on ASCM or TB diagnosis/treatment. Ideally, programs would be large and comprehensive enough to encompass both. In each category, the case studies are organized by country, with examples from India first, followed by examples from other countries. The following are some definitions of key terms used in the matrix:

- ***Advocacy*** = Activities to obtain political or government support or funding for TB initiatives

- ***Mass media =*** Radio/TV dramas, radio/TV ads, magazine/newspaper ads, public relations (earned media)

- ***Provider interpersonal communication and counseling (IPC/C) =*** IPC/C provided individually or in groups through health facilities, pharmacies/chemists or telephone hotlines.

- ***Community IPC/C and mid-media =*** IPC/C provided individually or in groups by community health volunteers or community health workers; includes self-help groups, TB clubs, sensitization meetings, community theater, posters, flyers, billboards, and collateral materials

- ***Digital media =*** mobile phones, video conferencing, websites, Facebook, Twitter, SMS messages

TB Case Studies

Name and Location	Activities/Channels	Objectives	Target Audiences	Good Practices
PROGRAMS WITH ACSM AS PRIMARY FOCUS				
1. ACSM for TB Control India (Odisha)	• Community IPC/C • Provider IPC/C	• Increase adoption of DOTS by health care providers • Increase ownership of DOTS by civil society • Increase access to DOTS in tribal and coastal areas	• General population • TB patients • Health care providers • Community-based organizations	• Extensive provider training/ support • Focus on sustainability • Innovative community channels • Robust research • Strong communication planning
2. Stop TB Partnership – Engaging the Private Sector to Increase TB Case Detection Pakistan	• Mass media • Community IPC/C and mid-media • Service expansion/ improvement • Digital media	• Increase the number of TB notifications to the NTP • Improve diagnosis and treatment of TB • Improve self-referral and hospital referral system	• Lower income households from all major ethnic groups	• Expanded case detection/diagnosis through social mobilization • Innovative use of technology • Robust research
3. Involvement of Religious Leaders (Operations Research) for TB Case Detection Pakistan	• Community IPC/C	• Assess the effectiveness of involving religious leaders in raising community awareness about TB to encourage TB suspects to seek medical advice earlier	• Religious leaders • Male household members	• Innovative community channels • Robust research • Strong media/community/health system linkages
4. Implementation of Tajikistan National TB Communication Strategy Tajikistan	• Mass media • Community IPC/C and mid-media • Provider IPC/C	• Increase coordination among stakeholders involved in TB programming • Strengthen key policymakers and implementing agencies through job training	• General population • Hospital nurses • Community volunteers and leaders • Journalists	• Expanded TB treatment/care through social mobilization • Extensive provider training/ support • Robust research • Strong communication planning • Strong/innovative partnerships

Name and Location	Activities/Channels	Objectives	Target Audiences	Good Practices
5. Maguindanao TB Control Project Philippines (Maguindanao)	• Advocacy • Provider IPC/C • Community IPC/C	• Leverage local resources to improve TB care-seeking behavior and community access to microscopy and DOTS services	• Health care providers • Local government units • TB patients	• Expanded case detection/diagnosis through social mobilization • Expanded TB treatment/care through social mobilization • Extensive provider training/support • Focus on sustainability • Participatory processes
6. Barangay TB Patrol Philippines (Bulacan)	• Community IPC/C • Service expansion/ improvement	• Strengthen community-level TB control activities • Strengthen health care provider communication skills • Increase case detection and treatment rates	• TB suspects and patients • Health care providers	• Expanded case detection/diagnosis through social mobilization • Focus on sustainability • Strong/innovative partnerships
7. Health Communication in National TB Program Vietnam	• Advocacy • Mass media • Community IPC/C and mid-media • Provider IPC/C	• Increase community awareness of TB and encourage people to practice healthier behaviors • Raise awareness about the burden of TB and make the fight against TB a priority at all levels to maintain political commitment • Strengthen individual and community involvement in TB-related activities	• General population • Health providers • Leaders at all levels • Journalists	• Adaptation of materials to local context • Addressed stigma • Focus on sustainability • Robust research
8. Strengthening TB Control in Moldova Moldova	• Mass media • Community IPC/C and mid-media • Provider IPC/C • Digital media	• Improve the knowledge and practices of public health care givers and the general population	• General population • Health care providers • Community leaders and volunteers • Journalists	• Addressed stigma • Innovative use of technology • Robust research • Strong communication planning
9. National TB Control Program	• Advocacy • Mass media • Community IPC/C and mid-media • Provider IPC/C	• Reduce TB stigma, especially among health care workers • Gain political support for the program • Raise awareness about TB in	• General population • Urban poor • "Closed populations" • Health care providers • Local, national, and	• Adaptation of materials to local context • Extensive provider training/ support • Strong/innovative

Name and Location	Activities/Channels	Objectives	Target Audiences	Good Practices
Peru		general, especially around the effectiveness of treatment and that diagnosis and treatment were available at no cost • Increase knowledge about TB case detection • Strengthen the link between health facilities and the community to improve case detection and treatment success. • Improve both passive and active case identification • Improve treatment compliance	international leaders	partnerships • Strong media/community/health system linkages
10. SOLUCION TB Mexico	• Advocacy • Mass media • Community IPC/C and mid-media	• Reduce TB-related stigma within the larger population and among health staff	• TB patients • General population • Health care providers • Church leaders	• Addressed stigma • Innovative community channels • Innovative use of technology • Strong/innovative partnerships
PROGRAMS WITH TB DIAGNOSIS/TREATMENT AS PRIMARY FOCUS				
11. Malkangiri Community DOTS TB project India (Odisha)	• Service expansion/ improvement • Provider IPC/C • Digital media	• Increase TB case detection and access to TB services • Develop community DOTS • Decrease social distance between service providers and communities • Develop a government–NGO interface for management of sputum collection, case detection, and supervision.	• People in difficult- to-reach tribal areas • Community DOTS providers • Health care providers	• Adaptation of materials to local context • Expanded case detection/diagnosis through social mobilization • Expanded TB treatment/care through social mobilization • Strong media/community/health system linkages

Name and Location	Activities/Channels	Objectives	Target Audiences	Good Practices
12. Project AXSHYA ("TB Free") India	• Advocacy • Mass media • Community IPC/C and mid-media • Provider IPC/C	• Improve the quality of TB services and increase access to vulnerable groups	• General population, with a special focus on women, children, marginalized, vulnerable, and TB-HIV co-infected populations • Men and women 15–54 years, rural and urban (mass media campaign) • Health care providers • Policymakers	• Adaptation of materials to local context • Extensive provider training/support • Strong/innovative partnerships • Strong media/community/ health system linkages
13. Operation ASHA India (New Delhi)	• Service expansion/ improvement • Community IPC/C • Advocacy	• Increase case detection • Reduce social stigma • Ensure zero-default on treatment	• People living in urban slums	• Expanded TB treatment/care through social mobilization • Focus on sustainability • Innovative community channels
14. BRAC Bangladesh	• Service expansion/ improvement • Community IPC/C and mid-media	• Achieve and sustain at least 70 percent case detection and 85 percent treatment success among smear-positive TB cases under DOTS	• Rural and urban poor • TB patients • Community health workers	• Expanded TB treatment/care through social mobilization • Extensive provider training/ support • Focus on sustainability • Participatory processes • Strong media/community/health system linkages
15. Damien Foundation Bangladesh	• Service expansion/ improvement • Community IPC/C and mid-media	• Improve access to quality TB care in villages	• People in rural areas • TB patients • Village doctors	• Addressed stigma • Expanded case detection/diagnosis through social mobilization • Expanded TB treatment/care through social mobilization • Strong media/community/health system linkages

Programs with ACSM as their Primary Focus

1. ACSM for TB Control in Odisha, India	
Donor: Global Fund **Implementing agency:** International Union Against TB and Lung Disease (The Union), Central TB Division (CTD)–Ministry of Health and Family Welfare	**Good practices:** • Extensive provider training/support • Focus on sustainability • Innovative community channels • Robust research • Strong communication planning
Duration: 2008–2010 **Geography:** India (Odisha)	
Publication/Source: A rapid assessment and response approach to review and enhance Advocacy, Communication and Social Mobilisation for Tuberculosis control in Odisha state, India. Kamineni, V. et al. *BMC Public Health*. 2011. 11:463.	

Background

Almost 40 percent of residents in India's Odisha (formerly Orissa) state live below the poverty line, making it the poorest state in India. The government RNTBP was launched in Odisha in 1997; all 31 reporting districts had been covered by 2004. Residents of Odisha have a higher risk of contracting TB than residents of other states, according to an "annual risk of TB infection" study conducted in 2003.

In 2007, the International Union Against TB and Lung Disease (The Union) was tasked with supporting the CTD–Ministry of Health and Family Welfare, to implement the ACSM component for TB control in Odisha. To understand the prevalent sub-national ACSM planning and programming, and to evaluate existing ACSM practices, The Union conducted a review of ACSM under the RNTCP in Odisha. Based on the ACSM review, an Odisha ACSM strategy was developed with the main goal of improving community ownership, involvement, and participation to drive TB control activities, with close consultation with all TB stakeholders and targeted beneficiaries in TB control planning and development.

Goals and objectives

Based on this strategy, The Union implemented an ACSM project with the following objectives: increased adoption of DOTS by all health care providers in Odisha; increased ownership of DOTS by civil society, including Panchayati Raj Institutions (local self-governing institutions), CBOs, and women's self-help groups; and increased access to DOTS services in tribal and coastal areas in the state.

Target audiences

The primary audience was the general population of Odisha and TB patients. Secondary audiences were frontline health care providers and CBOs.

Process and strategies

SM activities were carried out from April 2008 to December 2009. The project identified local NGOs to implement SM activities around community action for TB control and worked to deliver all SM interventions aimed at promoting community action. NGOs were to translate RNTCP policy into action, bridge gaps, and act as an "interface" between community and public sector stakeholders.

The project supported the NGOs in technical skills transfer on basic concepts of TB, and in material and financial resources to implement ACSM activities. Communication materials were designed to improve suspect referrals for TB diagnosis in areas with low case detection, focusing on the need for treatment completion/adherence in areas with poor treatment outcomes for TB, increase awareness of TB and the availability of free TB services at public sector facilities, and reduce stigma and discrimination. Sensitization workshops with community groups (self-help groups, traditional healers, alternative medical practitioners, senior TB treatment specialists) adopted tailored messages for audience segments in line with health communication objectives.

ACSM in Odisha Project Results

- Increased TB knowledge among traditional healers and AYUSHA doctors
- Improved knowledge of TB diagnosis and treatment among the general population
- Improved coordination among the health system, NGOs, and the community
- Re-energized interest in TB control within community groups
- Enhanced confidence and self-efficacy to conduct TB control activities among NGOs

Good practices

- **Extensive provider training/support:** The project strengthened the capacity of a wide variety of providers, including government DOTS providers, ASHAs, AWs, AYUSHA (alternative medicine) doctors, and traditional healers.
- **Focus on sustainability:** The project aimed to increase community ownership of TB control activities by engaging an unusually wide variety of stakeholders throughout the development and implementation process. The project also invested heavily in building the capacity of local "interface" NGOs to implement social mobilization activities. This included strengthening their technical TB skills, their financial and managerial skills, and providing them with financial support. The project also promoted sustainability by enhancing coordination between NGOs implementing community-based activities and health staff at multiple levels.
- **Innovative community channels:** The intervention utilized community channels that had not been traditionally involved in TB control such as self-help groups, traditional healers, and local self-governing institutions. The project also held sensitization meetings for special populations in low-performing areas, such fishermen, stone quarry workers, and slum dwellers.
- **Robust research:** The intervention was evaluated using a "rapid assessment" methodology consisting of a combination of qualitative and quantitative methods. These included key informant interviews, focus group discussions, and surveys with community members, implementation partners, health staff, and community-based health care providers.
- **Strong communication planning:** The project developed a state-specific ACSM strategy that that included tailored messages to address specific TB problems in low-performing areas. Messages were tied to health communication objectives.

2. Engaging Private Sector to Increase TB Case Detection	
Donor: Multiple **Implementing agency:** Stop TB Partnership	**Good practices:** • Expanded case detection/diagnosis through social mobilization • Innovative use of technology • Robust research
Duration: 2010–2011 **Geography:** Pakistan (Karachi)	

Publication/Source:

1) Engaging the private sector to increase tuberculosis case detection: an impact evaluation study. Khan, A. et al. *The Lancet*. August 2012. 12:8, pp. 608-616
2) *The Role of mHealth in the Fight Against Tuberculosis.* mHealth Alliance and Stop TB Partnership. No date.
3) Pakistan Stop Tuberculosis. WHO. http://www.emro.who.int/pak/programmes/stop-tuberculosis.html. Accessed December 8, 2013.

Background

Although free TB screening and treatment is available through national tuberculosis programs (NTPs) in most countries, an estimated 1.45 million people die from tuberculosis every year. This is largely due to low case finding, since many cases are never diagnosed to receive treatment. Pakistan is fifth among TB high-burden countries globally. It is also estimated be the fourth highest prevalence of multidrug-resistant TB. Engaging the private sector offers an untapped opportunity to ensure that high-quality diagnosis and treatment becomes the norm.

Goals and objectives

The Stop TB Partnership launched a communication campaign whose goal was to improve health-seeking behavior of people with two weeks or more of productive cough and get them to seek care at one of 54 private family medical clinics or a private hospital that was also an NTP reporting center. The campaign objectives were to:

- Increase the number of TB notifications to the NTP in the intervention area
- Improve diagnosis and treatment of TB
- Improve self-referral and hospital referral system

Target audiences

The broad target audience was lower-income households from all major ethnic groups in Pakistan.

Process and strategies

A one year-long mass communication strategy was implemented: billboards, cable television advertisements, posters, and flyers encouraged people with two or more weeks of productive cough to seek care at one of 54 private family clinics or at the private Indus Hospital (also an NTP reporting center), linking messages across all media platforms. Signboards at family clinics advertised free TB screening and treatment linked to the Indus Hospital, and banners were placed at major street junctions near the clinics. Two local cable campaigns in March and October, 2011, included hourly 90- to 120-second informational videos highlighting the signs and symptoms of tuberculosis and the free diagnostic and treatment services available.

Community laypeople participated as screeners, using an interactive algorithm on mobile phones to assess patients and visitors in family clinic waiting areas and the hospital's outpatient department. A team at the Indus Hospital in Pakistan was supported by a TB REACH grant from the Stop TB Partnership to use an integrated real-time, mobile phone enabled database. This catalyzed a novel TB treatment compliance and case holding scheme that worked by sending a monetary reward as incentive to the patient's or doctor's personal mobile phone. When texting these codes back to the hospital, patients were rewarded via a mobile money model in which cash could be collected or forwarded to other phone

customers anywhere in the country. Screeners received cash incentives for case detection through an electronic form on the mobile phone.

Community health workers with at least five years of experience supervised small groups of screeners, managed sputum collection, drug delivery, and ensured that home visits were not double counted by recording global positioning coordinates. The training for community health workers focused on NTP guidelines, TB awareness, counseling of patients, and sputum handling. Patients with suspected TB also came directly to the hospital's TB clinic by self-referral or by referral from others.

Screeners assessed patients and their escorts who attended family clinics and the outpatient department for TB symptoms. Anyone with a cough of three weeks or more in duration (or two to three weeks of productive cough), a previous history of TB, or a family member currently diagnosed with TB was suspected to have TB.

Screeners at family clinics received a monthly stipend of $23.50, plus cash incentives for submitting a daily phone report ($0.18), procuring an acceptable sputum sample ($0.88), and identifying a smear-positive case ($11.80) or other form of TB ($5.88).

Stop TB Partnership Project Results

- Threefold increase in the number of self-referrals to the Indus Hospital TB clinic
- Twofold increase in TB case detection in the intervention area

Screeners assessed 388,196 individuals at family clinics and 81,700 at the Indus Hospital's outpatient department from January–December 2011. A total of 2,416 tuberculosis cases were detected and notified via the NTP reporting center at the hospital: 603 through family clinics, 273 through the outpatient department, 1020 from self-referrals, and 520 from referrals. In the intervention area overall, tuberculosis case notification to the NTP increased two times (from 1569 to 3140 cases) from 2010–2011—over a 100 percent increase relative to the change in number of case notifications in the control area.

Good Practices

- **Expanded case detection/diagnostics through social mobilization:** The project expanded case detection by recruiting and training community laypeople to use mobile phones equipped with a TB screening app to identify new TB cases at family clinics and hospital outpatient departments. Doctors also received incentives for identifying TB cases. These strategies led to a four-fold increase in case detection in the catchment area.
- **Innovative use of technology:** The mobile phone software was used by screeners to collect, submit, and retrieve data to improve performance. The system allowed data entry and retrieval to a central database at the time of screening, identification of patients suspected of having TB via an interactive algorithm, and scheduling of sputum collection, treatment initiation, clinic visits, and drug dispersal. Technology improved treatment adherence. TB patients received monetary incentives via mobile phone for treatment adherence. Doctors also received incentives for supporting TB treatment. These strategies pushed treatment adherence to over 90 percent.
- **Robust research:** The project compared the number of cases notified to the NTP in the intervention area with the number of cases notified in the control group, over a one-year period. The overall effect of the intervention strategy was accessed by comparing the percentage change in case notifications by NTP reporting centers and in annual case-notification rates in the intervention versus control areas.

3. Involvement of Religious Leaders for TB case detection (Operations Research)	
Donor: World Health Organization (WHO) **Implementing agency:** Pakistan National TB Program, Mercy Corps, Baluchistan University, Bolan Medical College	**Good Practices:** • Innovative community channels • Robust research • Strong media/community/health system linkages
Duration: 2005–2006 **Geography:** Pakistan (Baluchistan)	
Publication/Source: 1) Impact of training of Religious Leaders about Tuberculosis on Case Detection Rate in Balochistan, Pakistan. *Journal of Pakistan Medical Association*. Pirkani, G. et al. 2009. Vol. 59. No. 4 (Supp 1). 2) Pakistan Stop Tuberculosis. WHO. http://www.emro.who.int/pak/programmes/stop-tuberculosis.html Accessed December 8, 2013.	

Background

Pakistan is fifth among TB high-burden countries globally. It is also estimated have the fourth highest prevalence of multidrug-resistant TB. Pakistan is 98 percent Muslim, with religion playing a major role in people's daily lives.

Goals/objectives

A study was done to involve religious leaders in raising community awareness about TB to encourage TB suspects to seek medical advice earlier. The religious leaders' knowledge of was assessed through a questionnaire, which was followed by training to enable them to educate the community about TB in their weekly sermons and through personal contacts.

Target audiences

The primary audience was religious leaders in Baluchistan and male household members.

Process/strategies

A total of 87 religious leaders were included in the study, 42 in the intervention and 45 in the control districts in Baluchistan. To evaluate the impact of the intervention, TB patients and religious leaders were interviewed after the intervention, and case notification rates in the intervention and control districts were compared.

An intervention study was conducted whereby three intervention and three control districts were randomly selected from the province. All eligible religious leaders were included in the study. Using a questionnaire, baseline information was collected on religious leaders' knowledge of TB and health services delivering TB care, and on their willingness to raise community awareness about the disease and adequate health-seeking behavior. Religious leaders in the intervention districts were given a one-day training program on TB and ways to guide the community to seek timely and appropriate care.

The following educational messages were delivered to male householders during the weekly service: an individual suffering from cough for more than three weeks is considered a TB suspect and should seek immediate care at the TB center for diagnosis and treatment, if confirmed to be an active TB case; TB is a curable disease; the treatment is free of charge at the designated NTP centers.

The acceptability of having religious leaders deliver educational messages and being involved in raising community awareness was evaluated. The impact of the intervention was assessed by interviewing TB suspects at health facilities and comparing the case notification and case detection rates before and after the intervention in both the intervention and control districts.

Involvement of Religious Leader Study Results

- Increase in knowledge of TB symptoms and the availability of TB treatment among religious leaders
- Increase in TB notification and detection rates in the intervention district
- Increase in knowledge of duration of TB treatment and identification of religious leaders as a source of information about TB among patients in control district

Good practices

- **Innovative community channels:** The intervention took advantage of the important role that religion plays in the daily lives of Pakistanis. Religious leaders raised awareness about TB and seek medical advice earlier by delivering messages during weekly sermons and through personal interactions with community members.
- **Robust research:** Extensive baseline and endline studies were carried out to measure the results of the intervention. Three intervention and three control districts were randomly selected within the province. By the end the intervention, knowledge of cough as the main TB symptom and the definition of a TB suspect increased. Following the intervention, intervention districts reported significantly higher case notification and detection rates compared to the control districts.
- **Strong media/community/health system linkages**: Through the innovative use of religious leaders to increase TB awareness, the intervention also strengthened community links with the health system. Because religious leaders are trusted sources of information, the community and health staff could join forces to have a significant impact on the TB case detection rates.

4. Implementation of the Tajikistan National TB Communication Strategy

Donor: Global Fund, USAID

Implementing agency: Project Hope

Technical assistance: JHU–CCP

Duration: 2004–2009

Geography: Tajikistan

Good practices:

- Expanded TB treatment/care through social mobilization
- Extensive provider training/ support
- Robust research
- Strong communication planning
- Strong/innovative partnerships

Publication/Source:

Advocacy, Communication, and Social Mobilization for TB Control: Collection of Country Level Good Practices. WHO. 2010.

Background

The post-communist social and economic disruptions of the 1990s had a negative effect TB control efforts in Tajikistan. During this period, many TB cases went undetected, treatment was largely unavailable, and the rate of TB related mortality experienced significant increase. External partners and

the government initiated DOTS efforts to address the situation in mid-2002, and achieved 32 percent reach of the total population by 2004 and 100 percent DOTS coverage by 2007. Despite this, major gaps existed in the availability of TB communication materials for health staff, TB patients, and the general population. In addition, a legacy of the former communist system was that providers' technical and communication skills were poor and patient-unfriendly. A lack of coordinated efforts by key players also stalled awareness-raising efforts about TB symptoms and treatment. SBCC activities were being conducted by individual implementing organizations without coordinating with counterpart groups.

Goals and objectives

The goal was to increase the coordination among stakeholders involved in TB programming and strengthen the capacity of key policymakers and implementing agencies through job training. Project Hope aimed to accomplish this through the development of a national TB communication strategy.

Target audiences

The primary target audience was TB hospital nurses. Secondary audiences were community leaders and volunteers and general population. The tertiary audience was journalists. By focusing on larger influencers, the project helped create an enabling environment for the adoption of positive healthy behaviors.

Process and strategies

To effectively gauge communication gaps, the project conducted a baseline assessment. The exercise consisted of a KAP survey of health providers, TB patients, and the general population, and focus group discussions with TB patients. The findings revealed an urgent need to help health care providers improve the quality of their patient communication and education. Nurses were shown to require better training, with 84 percent of those surveyed exhibiting inadequate knowledge of the disease. Patients also demonstrated a low level of understanding of TB, with nearly 19 percent of respondents believing a five- to six-month stay in hospital was required, and 70 percent unaware that TB treatment is free in Tajikistan.

To overcome these barriers, the project coordinated training and guidance for members of an ACSM working group that had been established under the NTP. The training focused on developing a TB communication strategy; developing and pretesting communication materials; and monitoring and evaluating communication activities. The national TB communication strategy focused on various audiences for communication training and included the coordination of several community-oriented education activities. Those trained under the strategy included 40 TB hospital nurses (trained in IPC), as well as approximately 300 community volunteers and leaders, who were trained to carry out health education sessions for the general public.

The project also trained nurses to implement an in-service counseling program to support treatment providers. Project staff developed communication materials, including booklets, brochures, posters, and video and radio public service announcements (PSAs) that were aimed at both TB patients and the population at large. The project facilitated the creation of TB toolkits for use by patient education providers,

Tajikistan Project Results

- Increase knowledge among the general public about TB causes, effects, and treatment duration

including a diagnostic algorithm, a booklet on sputum collection, and a brochure on TB drugs' side effects and how to administer treatment using them. Community leaders were selected and trained to work with their community members to provide key messages on TB and to assist medical workers with DOT by taking TB drugs to patients who were unable to travel to health facilities to receive their daily dosage. The project carried out a media program, which broadcast TB PSAs on radio and TV. The media program included annual workshops for journalists to promote coverage of TB issues. The project carefully segmented audiences (health staff, community leaders, and journalists) and developed separate BCC materials for each.

At the community level, 5,780 community volunteers and leaders were trained, allowing them to reach more than 700,000 people through coordinated SBCC activities. Volunteers also supported 1,519 TB patients in DOT. At the health facility level, 128 nurses were trained in IPC and counseling skills. Over one hundred journalists from national and regional television and radio stations and print newspapers were trained on TB information and treatment.

Good practices

- **Expanded TB treatment/care through social mobilization:** The project recruited and trained community volunteers to support TB patients receiving DOTS. This included bringing medicine to patients who could not travel to health facilities for treatment.
- **Extensive provider training/support:** The project's baseline assessment identified nurses as the category of health care provider most in need of training. The project trained 128 nurses in IPC, in addition to over 5,000 community volunteers. A suite of communication materials was developed to support counseling, including TB toolkits containing a diagnostic algorithm, a booklet on sputum collection, and a brochure on TB drugs' side effects and how to administer treatment using them.
- **Robust research:** The project conducted a comprehensive baseline assessment to assess the communication gaps around TB in country. This included a baseline KAP survey and focus group discussions with health providers, TB patients and the general population. A follow-up KAP survey evaluated the effectiveness of the communication program.
- **Strong communication planning:** The project trained the national ACSM working group on how to develop a communication strategy and develop and pretest communication materials. The project then helped the working group to develop a national strategy focusing on health provider training and community-based education.
- **Strong/innovative partnerships:** The project partnered with the media to convey correct information about TB by training over 100 journalists in a series of annual workshops.

<table>
<tr><th colspan="2">5. Maguindanao TB Control Project</th></tr>
<tr><td>Donor: USAID

Implementing agency: Maguindanao Integrated Provincial Health Office and Catholic Relief Services (CRS)</td><td rowspan="2">Good practices:
• Expanded case detection/diagnosis through social mobilization
• Expanded TB treatment/care through social mobilization
• Extensive provider training/support
• Focus on sustainability
• Participatory processes</td></tr>
<tr><td>Duration: 2005–2009

Geography: Philippines (Maguidanao)</td></tr>
<tr><td colspan="2">Publication/Source:

Advocacy, Communication, and Social Mobilization for TB Control: Collection of Country Level Good</td></tr>
</table>

Practices. WHO. 2010.

Background

Even though the province of Maguindanao has achieved case detection and treatment rate improvements that bring it close to the national average, substantial gaps remain among its 33 municipalities. The low performance of some of them is because of ongoing armed conflict in the province. This has resulted in the displacement and evacuation of families, which adversely affect the implementation of TB activities. TB control efforts are further delayed by a lack of coordination between private facilities and rural health units, and a lack of key health staff at public health facilities.

Goals and objectives

The goal of the intervention was to leverage local resources to improve TB care-seeking behavior and community access to microscopy and DOTS services and reduce the TB morbidity and mortality by 2009.

Target audiences

The primary target audience was health providers. TB patients and local government units were secondary audiences.

Process and strategies

The project identified major gaps and challenges in implementation of TB control activities that could be addressed through ACSM activities. Some of the barriers to the delivery of TB care included low health staff technical competency, irregular supervision of municipal staff, poor access to services because of geographic terrain and ongoing conflict, and TB-associated stigma.

From the outset, the project had to factor in the volatility of the security situation caused by armed separatist groups. To deal the intensifying conflict, the project worked with the Integrated Provincial Health Office Maguindanao's Quick Disaster Response Team to track patients and defaulters. The project conducted a rapid assessment of the impact on the program caused by the displacement of some communities from the province, tracking patients who either had been placed in evacuation centers or were home-bound to ensure treatment compliance. The project developed an ACSM strategy to address obstacles to TB diagnosis, treatment, and care identified during the baseline survey.

The strategy included advocacy efforts, lobbying local government units to make TB prevention a priority and to allocate the needed resources to the project. The project also engaged existing community support groups to assist in DOTS implementation. This multi-channel approach focused on the intended audience, including the needs, culture, and local context in Maguindanao.

The project conducted ACSM workshops (including one that focused on BCC for health staff); reactivated 11 local health boards to plan and solicit for greater political support for TB; and developed several community engagement and patient empowerment approaches to improve case finding and treatment success rates. To improve communication between care providers and receivers and increase community buy-in to the program, local health staff, patients, and community members participated in all aspects of strategy implementation.

The program's ACSM components included: training service providers to conduct individual counseling of all patients before initiation of treatment and reorganizing individual staff tasks to address work overload; conducting ongoing TB education sessions at the health center for patients; and conducting home visits by health volunteers to track those who default on treatment and counsel patients and family members.

Maguindanao Province only had 10 medical technologists, making it difficult to do large-scale TB diagnoses. The project expanded laboratory services by training 168 *barangay* (village) health workers (BHWs). BHWs were trained in sputum collection and smearing and were supervised by provincial and municipalTB coordinators.

TB clubs for people under treatment were also established, with former patients serving as counselors. Clubs consisted of 6 to 12 members and met on a regular basis. The composition of the individual clubs was fluid, as new patients would enroll and successfully treated patients would leave the club.

Maguindanao Project Results

- Increase in TB referrals by village health workers
- Increase in TB case detection rates
- Decrease in stigmatizing attitudes and increase in supportive attitudes among the general public

Good practices

- **Expanded case detection/diagnosis through social mobilization:** Village health workers were trained in sputum collection and smearing, providing a much needed expansion of diagnostic services. The health workers were supervised by TB coordinators at the provincial and municipal levels.
- **Expanded TB treatment/care through social mobilization:** The project mobilized communities to support patients undergoing treatment by establishing TB clubs and implementing home visits by health volunteers.
- **Extensive provider training/support:** The project not only strengthened the ability of providers to counsel TB patients, but also addressed work overload by reorganizing staff tasks within the health care system.
- **Focus on sustainability:** The project used advocacy strategies to lobby local government units to make TB prevention a priority and to allocate the needed resources to the project. Local health boards were re-activated to plan and solicit greater political support for TB. The project also engaged existing community support groups to assist in DOTS implementation. Both of these approaches could contribute the long-term sustainability of the intervention.
- **Participatory processes**: Health providers, patients, and community members were involved in all stages of the intervention to ensure that all voices where heard throughout the process. This increased community buy-in to the project.

6. Barangay TB Patrol	
Donor: Government of the Philippines **Implementing agency:** Provincial Government of Bulacan	**Good practices:** • Expanded case detection/diagnosis through social mobilization • Focus on sustainability • Strong/innovative partnerships
Duration: 2009–ongoing **Geography:** Philippines (Bulacan)	

Publication/Source:

Advocacy, Communication, and Social Mobilization for TB Control: Collection of Country Level Good Practices. WHO. 2010.

Background

Although the government of the Philippine province of Bulacan has followed the National TB Control Program, TB has remained one of the 10 leading causes of mortality in the province for the last five years. The province has one of the highest rates of TB prevalence in the Philippines. The case detection rate (62 percent) and cure rate (81 percent) remain well below the national averages (75 percent and 85 percent, respectively). The province also has a relatively high TB mortality record, with annual deaths ranging from 367 to 439 from 2005–2008. Low case detection is worsened by a lack of strategic activities at the local level, as well as weak program management skills of providers, particularly in monitoring and supervision, program planning and communication. The province's low treatment success is in part due to a lack of effective strategies in patient follow-up during treatment, which results in low levels of sputum examination and treatment compliance.

Goals and objectives

The goal of the Barangay TB Patrol is to strengthen community-level TB control, strengthen health staff communication skills, and increase case detection and treatment rates.

Target audiences

Primary audiences were TB suspects and patients in Bulacan. The secondary audience was health providers.

Process and strategies

An "anti-TB task force" was formed to undertake a coordinated program aimed at strengthening TB control activities at the community level. Some of the task force's goals included fostering public policies that support local initiatives, and developing the skills of both health workers and community volunteers to detect cases of TB and to educate community members on how TB is spread. The provincial health office staff, who led program implementation, involved various community groups in planning and implementing the project, including the council of the local Catholic parish, women's groups, Rotary Club, local schools, *barangay* (village) volunteers, and health workers. Together, they developed the idea of the task force, which they named "the *Barangay* TB Patrol" (BTBP), consisting of a mix of community leaders and health workers who provide TB education and case finding services in low case detection areas. The task force members are charged with: 1) formulating TB health plans in coordination with municipal health offices; 2) educating clients (TB suspects and patients) on basic TB facts, misconceptions, and DOT treatment protocols; 3) identifying and referring TB suspects to DOTS centers; 4) acting as treatment partners; and 5) serving as a TB advisory group for the Barangay Council on TB-related matters.

Trained in TB and DOTS, BTBP members also received

Barangay TB Patrol Results

- High coverage rate for home visits by the Barangay TB Patrol
- Expansion of the program to other villages

training in awareness raising techniques, case detection, conducting house-to-house campaigns to educate community members on TB and DOTS and identification of TB suspects and referral to DOTS centers. Patrol members also organized community assemblies to disseminate TB information and set up TB exhibits at seven local hospitals.

Good Practices

- **Expanded case detection/diagnosis through social mobilization:** The BTBP members were trained in TB case detection. They visited over 7,000 households, representing 71 percent of the population in the project sites. Over 600 TB suspects were referred to the local health facility.
- **Focus on sustainability:** Led by the provincial TB program, key stakeholders from various sectors mobilized to address TB rates within their communities. This grass roots approach continued beyond the intervention and was expanded to 47 other communities within the province.
- **Strong/innovative partnerships:** The creation of an "anti-TB task force" was the result of a partnership between local government (the provincial health office) and community organizations, including the council of the local Catholic parish, women's groups, Rotary Club, local schools, and barangay (village) health workers. This partnership allowed the community to play an active role in changing TB behaviors.

7. Health Communication in National TB Program in Vietnam	
Donor: USAID **Implementing agency:** JHU–CCP	**Good practices:** • Adaptation of materials to local context • Addressed stigma • Focus on Sustainability • Robust research
Duration: 1998–2002 **Geography:** Vietnam	
Publication/Source: 1) *Health Communication Insights*. *The Role of Communication in Vietnam's Fight Against Tuberculosis.* Thuy, D.O., Huong, N.T.M., Tawfik, Y., and Church-Balin, C. Baltimore: Health Communication Partnership based at Johns Hopkins Bloomberg School of Public Health–Center for Communication Programs. 2004. 2) *Health Communication Insights Summary*. *The Role of Health Communication in Achieving Global TB Control Goals: Lessons from Peru, Vietnam and Beyond.* Thuy, D.O., Llanos-Zavalga, F., Huong, N.T.M., Poppe, P., Tawfik, Y., and Church-Balin, C. Baltimore: Health Communication Partnership based at Johns Hopkins Bloomberg School of Public Health–Center for Communication Programs. 2004.	

Background

At one time, the Vietnamese considered TB incurable and hereditary. These misconceptions created stigma and discrimination and led to barriers for reaching and treating TB patients. The program's leaders recognized that strategic health communication was indispensable to the NTP's success. A robust health communication component was developed to change people's misperceptions and eliminate stigma by providing accurate TB information.

Goals and objectives

The goal of the intervention was to contribute to achieving the national targets of detecting 70 percent of infectious cases and successfully treating 85 percent of these. Specific communication goals included:

- Increasing community awareness of tuberculosis and encouraging people to practice healthier behaviors related to TB.
- Raising awareness about the burden of TB and making the fight against TB a priority for local leaders at all levels, the ministries, social organizations, and the community to maintain political commitment and resources for TB-related activities.
- Strengthening individual and community involvement in TB-related activities.

Target audiences

The primary target audience was the general Vietnamese population, secondary audiences were health providers, and tertiary audiences were leaders at all levels and journalists.

Process and strategies

The program carried out formative research to understand how people received information about TB. Surveys were carried out in eight selected provinces that represented all regions of the country. The respondents ranked mass media as the number one way they receive information about health topics. Local radio networks were found to reach district, commune, and village/hamlet levels. Vietnam's high literacy rate made print media a key channel for increasing TB knowledge.

Activities around advocacy included conducting seminars on TB prevention and control, establishing TB control steering committees at all levels, distributing fact sheets and letters to authorities and local leaders, supporting journalists and reporters, organizing study tours and inviting leaders to international conferences, creating relationships with international organizations, and organizing public meetings in crowded locations.

Mass media activities consisted of radio, TV, and print materials. The program developed entertainment–education TV series, song and dance scripts, and video spots to raise awareness, legitimize the topic of TB, and motivate behavior change.

The NTP also provided financial support for 13 provinces in the northern mountainous area, High Land, and the southwest to develop print materials for ethnic minorities in H'Mong, Thai, Ede, Khmer, and Chinese. The program ensured that materials were adapted to the literacy and language needs of ethnic minorities and those living in hard-to-reach areas.

IPC and counseling activities focused on organizing training courses on health communication and counseling skills for program trainers in the provincial centers. The provinces then facilitated training courses on communication skills for health personnel engaged in TB-related activities and village health motivators.

Vietnam TB Communication Program Results

- High levels of awareness of TB symptoms and treatment among the public and health care providers
- Increase in number of TB cases detected

Community mobilization activities worked to establish partnerships with community-based organizations to offer various activities for their members and the community. In the five provinces with TB hospitals, provincial TB centers organized a group of fully recovered patients who received training courses on TB knowledge and communication skills. Former patients then

counseled current TB patients and also participated in TB advocacy meetings at the hospital and in the community. Several provinces also conducted activities such as "Questions and Answers" on TB and school-based competitions around TB.

Good practices

- **Adaptation of materials to local context:** Communication materials were specifically adapted to the country's various ethnic minorities and special were efforts made to distribute materials in hard-to-reach areas.
- **Addressed stigma:** The program addressed stigma through advocacy and awareness-raising efforts at the national and community levels. Stigma was also addressed through IPC activities by health staff and former TB patients.
- **Focus on sustainability:** The project conducted a robust suite of advocacy activities to gain political support for the program—a key factor in sustainability. These included establishing TB control steering committees at all levels, media advocacy, and study tours.
- **Robust research:** Formative research in the form of eight surveys was conducted to inform communication activities, such as channel preference for health topics. A KAP survey conducted to evaluate the program found significant increases in TB knowledge.

8. Strengthening TB Control in Moldova	
Donors: USAID, Global Fund **Implementing agencies:** American International Health Alliance (AIHA), Centre for Health Policies and Studies (PAS Centre)	**Good practices:** • Addressed stigma • Innovative use of technology • Robust research • Strong communication planning
Duration: 2004–2008 **Geography:** Moldova	
Publication/Source: *Advocacy, Communication, and Social Mobilization for TB Control: Collection of Country Level Good Practices.* WHO. 2010.	

Background

The TB situation in Moldova declined sharply after the collapse of the Soviet Union. The spread of TB reached epidemic numbers in the 1990s because of a socioeconomic crisis, insufficient financing of the health care system, and a lack of anti-TB drugs in the country. In 2001, the Government of Moldova established its NTP and began implementations of DOTS; TB still affected 108.3 per 100,000 people in 2003. The high incidence rate was a result of widespread misunderstanding about TB on by general public and health workers.

Goals and objectives

The goal of the intervention was to improve the knowledge and practices of public health care givers and the general population.

Target audiences

The primary target audience was the general Moldovan population. The secondary audiences were health providers, community leaders, and volunteers. The tertiary audiences was journalists.

Process and strategies

A national TB campaign was launched by AIHA in 2004 under USAID's Strengthening TB Control in Moldova project. The campaign motto was, "TB can be treated! See a doctor!" Components of this early phase of the campaign included TV and radio PSAs, brochures, posters, flyers, and peer education activities in schools and colleges. AIHA also worked with the Moldova State Medical University's School of Public Health to conduct 20 videoconferences on TB for approximately 500 medical professionals from all regions of the country. This was one of the first instances of modern distance learning techniques being applied in Moldova.

In 2007 the campaign was taken on by the PAS Center and continued with funding from the Global Fund. The PAS Centre tailored campaign content and information packages to the needs of the intended audiences in the nation's different districts and regions. The project undertook a KAP survey in 2004 to measure the national awareness and understanding of TB. The KAP found that although most were familiar with the main symptoms of TB, they had low knowledge on the mode of transmission, did not believe that TB could be cured, and were unaware that treatment was free of charge. There was also weakness of TB knowledge among primary health care providers, especially regarding the value of DOTS activities. Health staff did not fully understand their roles in TB control, which they viewed as being limited to case detection.

Based on the findings, the project decided to focus on activities to raise Moldovan awareness of TB as a curable disease and that diagnosis and treatment are offered free of charge. The PAS Centre developed a branded communication kit, including educational videos and brochures, poster-calendars, and communication guides for various audiences.

Each material was catered to its intended audience with a specifically tailored message, while always making a central theme, "TB can be treated." Some of the activities focused on primary health-care workers to help improve knowledge of DOTS and TB diagnosis and treatment. Some targeted the general population in districts burdened by high prevalence of TB and HIV/AIDS. Others focused on reaching such vulnerable groups as injection drug users (IDUs) and people living with HIV/AIDS (PLHIV).

Each of the campaigns consisted of a series of events conducted over two to three months. Events included TV and radio broadcasts of brief educational segments, programs to distribute printed materials and initiatives to have information teams and NGO volunteers conduct meetings with the public or target groups. The project directed a media campaign that was consistent nation-wide, but that featured different messaging for individual target groups. The campaigns aimed to: 1) lower the stigma endured by TB patients, a group commonly associated with the lowest levels of society; and 2) raise awareness that TB is curable and treatment is free.

Moldova Public Awareness Campaign Results

- Increase in public awareness of TB, its causes, and availability of free treatment
- Increase in knowledge of TB transmission and the fact that it is treatable

The program utilized a variety of channels of communications, including TV, radio, NGO workers, journalists, and medical practitioners. It also placed flyers and informational material in such heavily trafficked locations as post offices, social service agencies, and on public transport. Because of the wide range of materials it distributed through several channels, the PAS logo—a dandelion—was widely recognized across the country.

Good practices

- **Addressed stigma:** The project worked to address stigma by using multiple channels such as TV, NGO workers, journalists, and print materials in high-traffic locations.
- **Innovative use of technology:** Medical providers were trained through video conferencing—a cost-effective way to reach large numbers of geographically dispersed providers at one time.
- **Robust research:** KAP surveys were conducted prior to program design and post implementation to access effectiveness of the intervention. Project activities resulted in significant increases in TB knowledge.
- **Strong communication planning:** The project based its campaigns on solid formative research and did an excellent job of developing communication guides and messages for different target audiences, such as IDUs and PLHIV, while unifying materials under one theme. The project also utilized a mix of communication channels to reach target audiences through the media and at the community level.

9. Role of Communication in Peru's National TB Control Program	
Donor: USAID **Implementing agency:** Peru National TB Control Program, Ministry of Health **Technical assistance:** Johns Hopkins University-Center for Communication Programs (JHU–CCP)	**Good practices:** • Adaptation of materials to local context • Extensive provider training/ support • Strong/innovative partnerships • Strong media/community/health system linkages
Duration: 1991–2000 **Geography:** Peru	
Publication/Source: *Health Communication Insights. The Role of Communication in Peru's Fight Against Tuberculosis.* Llanos-Zavalaga, F., Poppe, P., Tawfik, Y., Church-Balin, C. Baltimore: Health Communication Partnership based at Johns Hopkins Bloomberg School of Public Health–Center for Communication Programs. 2004.	

Background

Communication activities were developed to respond to the barriers operating in the Peruvian context; formative research found that stigma against TB patients in Peru is passed down from generation to generation.

Goals and objectives

The overall goal of the campaign was to detect 70 percent of infectious TB cases and treat 85 percent of these. Objectives included:

- Reducing stigma about the disease, especially among health care workers.
- Gaining support from political, governmental, international, and local leaders for the program.
- Raising awareness about TB in general, especially around the effectiveness of treatment and that diagnosis and treatment were available at no cost.

- Increasing knowledge about TB case detection.
- Strengthening the link between health facilities and the community to improve case detection and treatment success.
- Improving both passive and active case identification by building health care workers' capacity to approach and counsel patients.
- Improving compliance with treatment by motivating patients and supporting volunteers, family members, and the community.

Target audiences

The primary target audiences were the general Peruvian population, the urban poor, and closed populations. Secondary audiences were health care providers and leaders at the local, national, and international levels.

Process and strategies

The program carried out formative research to assess the public and health care workers' knowledge of and attitudes about TB. The research found that stigma toward TB patients in Peru was common and passed down from generation to generation. There were also widespread misconceptions among health workers about how TB is transmitted.

The campaign activities included advocacy, mass media, IPC and counseling, and community mobilization. The NTCP helped organize high-visibility events on World TB Day, including parades and other public gatherings. It organized TV and radio coverage of important TB-related events.

Television and radio spots were aired to raise community awareness about TB, correct common misconceptions, motivate patients to seek care, and encourage the public to participate in Peru's fight against TB. Among the messages developed to encourage the public to help others seek care, the widely recognized slogan, "If you cough for more than 15 days, you should go to the health center," was integrated at various program levels. One strategy was to use the word "free" to appeal to low-income groups. To address health care providers' misperceptions about TB and TB patients, the NTCP trained all government health staff at all levels in IPC and counseling skills. The training focused on health workers' first contact with patients and targeted the providers' fear of infection by teaching them how to avoid TB while still being welcoming to patients.

The NTCP developed a counseling flipchart, adapted it for urban and rural audiences, and then disseminated it to clinics to guide staff and volunteers on how to counsel patients, families, and the general public. Video spots about TB were designed and disseminated to health care providers to show in health care facility waiting areas, and then to supplement with follow-up conversations with patients. Health staff also organized home visits to reinforce the link between the clinic and households. Home visits included discussions around TB messages, case detection and treatment, and follow-up.

The NTCP also carried out several advocacy activities, such as public events around World TB Day, to keep TB at the forefront in the minds of political and community leaders and the public. The NTCP invited the press to meetings of the Association of TB Patients to generate interest and media coverage of TB as a political issue.

Establishing strategic partnerships was also a key part of the strategy. The NTCP formed partnerships with several international organizations, donors, national associations, and NGOs. Churches and local community-based organizations were engaged to reach out to the community and provide a link to health clinics. The NTCP took the lead in coordinating partner support that included technical assistance, procurement of drugs and support to laboratory services, advocacy, training, and mobilization activities. Links were made with private practitioners, since the NTCP saw that private practitioners were important sources of care for TB patients. Private practitioners were invited to meetings and training sessions, and their data on TB cases were added to the NTCP information system. Private practitioners were reached through a partnership with the pharmaceutical industry. Pharmaceutical company representatives disseminated NCTP communication materials to private practitioners.

The consistent and widespread use of the NTCP logo in television and print media and at service sites led to wide recognition that helped the public easily identify TB service sites. Print materials (posters, billboards) were designed and funded at the local level and available in local Quechua and Aymara languages. A simple counseling flipchart was developed at the national level and adapted for urban and rural audiences.

Peru Communication Campaign Results

- Designation of TB as a priority by Peru's national health program and increased resource allocation
- Increase in detection of TB cases
- Increase in treatment adherence

Good practices

- **Adaptation of materials to local context:** Materials that were developed at the national level were adapted to both urban and rural contexts and available in local languages. Posters and billboards were developed and funded at the municipal level.
- **Extensive provider training/ support:** All government health providers at all levels were trained in counseling skills for TB. The trainings specifically focused on health workers' first contact with patients and targeted the providers' fear of infection.
- **Strong/innovative partnerships:** The NTCP worked hard to establish relationships with international and national partners and coordinated partner support. Special efforts were made to engage and involve CBOs, churches, pharmaceutical companies, and private practitioners. The NTP added data from private practitioners to its information systems.
- **Strong media/community/health system linkages:** Communication activities at all levels were interlinked and closely coordinated. The project logo was used on mass media materials and printed materials at all levels. This facilitated wide brand recognition and public awareness of TB service sites. The project obtained media coverage for community-based events, such as meetings of the Association of TB Patients.

10. SOLUCION TB (Strengthening Observed therapy Linking- Up Community-based Integrated Outreach Networks for TB control) in Mexico	
Donor: USAID **Implementing agency:** Project Concern International, Institute of Public Health Services (ISESALUD)	**Good practices:** • Addressed stigma • Innovative community channels • Innovative use of technology

Duration: 2004–2008 **Geography:** Mexico (Baja California and Sonora)	
Publication/Source: 1) *Advocacy, Communication and Social Mobilization to Fight TB. A 10-Year Framework for Action.* WHO. 2006. 2) *Advocacy, Communication, and Social Mobilization for TB Control: Collection of Country Level Good Practices.* WHO. 2010.	

Background

In 2008, the National TB Program (NTP) in Mexico reported 18,810 new cases. In addition to the high rate of new cases, the national health system suffered from chronic delays in seeking care and low treatment adherence rates. In Sonora State, the TB challenge was heightened by unusually high rates of mobility and migration and a desert environment, which created difficulties in treatment adherence and effective outreach (to get people to come to health facilities for diagnosis).

Goals and objectives

The goal of the ACSM components of the program was to reduce TB-related stigma within the larger population and among health staff.

Target audiences

The primary audience was TB patients and the general population in Sonora State. Secondary audiences included health providers and Catholic Church leaders.

Process and strategies

The program used multiple channels to achieve its goals. TB patients were encouraged to publicly share their TB experiences through forums, conferences, media interviews, support group meetings, and training workshops for health staff. The project has also helped raise awareness of the disease. Photography and narratives were used to share experiences of TB patients and displayed for the wider public, which humanized the disease and educated decision makers, health care providers, and the public on what TB means for those who are affected by it. The intervention developed television videos, radio spots, and Photovoice ("Voices and Images of TB") exhibitions during World TB Day.

The empowerment of TB patients through their participation in advocacy efforts and sharing their stories helped them to take on a more public role in sharing with a wider audience the experience of living with TB. This process led to reduced stigmatization by health providers and the general public and increased levels of state support for preventative programs.

The ACSM element of SOLUCION TB also included community outreach activities. Church leadership was also engaged and a collaboration with clerical staff resulted in TB information being included in weekly church bulletins, speeches and individual outreach efforts conducted at the church exits. Church officials became more proactive partners in the effort to educate their constituents about TB.

In addition to the Catholic Church, the project also collaborated with Sonora State administration. Project staff seized the opportunity to carry out TB presentations to the many people standing in queues at administration centers, as migrant status requires regular visits to municipal agencies to satisfy documentation requirements. The Sonora government broadcast TB messaging at carnivals, sporting events, and parades, as well as on billboards in major cities. TB patients also successfully lobbied state officials and decision makers for logistical support. These efforts resulted in the donation of an ambulance and a motorcycle, which improved patient supervision and contributed to increased treatment adherence.

SOLUCION TB Results

- Increase in the number of people tested for TB
- Decrease in treatment default rates
- Decrease in stigma among health care workers and the public
- Increase in levels of state support for preventive programs

Good practices

- **Addressed stigma:** The project focused on reducing stigma through innovative use of photography and narratives at public exhibitions. TB patients also shared their experiences through forums, conferences, media interviews, support-group meetings, and training workshops for health staff.
- **Innovative community channels:** The program worked closely with the Catholic Church and reached a weekly captive audience through Sunday masses. Project staff took advantage of long lines to educate people standing in line to file migrant status paper work at administrative centers. TB messages were also broadcast at carnivals, sporting events, and parades.
- **Innovative use of technology:** TB patients were given cameras to document the impact of TB on their lives following the Photovoice approach. This participatory approach helped TB patients to use their own stories as a catalyst for changing stigmatizing attitudes in society.
- **Strong/innovative partnerships:** By establishing a strong relationship with the local and Sonora State governments, the project disseminated TB information to migrant workers waiting to complete documentation requirements and mobilized the government to disseminate TB messages at various state-sponsored community events.

Programs with TB Diagnosis/Treatment as Primary Focus

<table>
<tr><th colspan="2">11. Malkangiri Community DOTS TB Project</th></tr>
<tr><td>Donor: Danish Assistance to the Revised National Tuberculosis Control Program in India (DANTB)
Implementing agency: DANTB
Creative agency: New Concept</td><td rowspan="2">Good Practices:
• Adaptation of materials to local context
• Expanded case detection/diagnosis through social mobilization
• Expanded TB treatment/care through social mobilization
• Strong media/community/health system linkages</td></tr>
<tr><td>Duration: 2005–2006
Geography: India (Odisha)</td></tr>
<tr><td colspan="2">Publication/Source:
1) Accessing TB Services in a Tribal District, The Malkangiri Project, Orissa. DANTB. 2006.
2) TBC India. Directorate General of Health Services. Accessed November 11, 2013. Ministry of</td></tr>
</table>

Health and Family Welfare. http://tbcindia.nic.in/RNTCP_Creatives.html

Background

In 2005 DANTB developed a TB intervention in partnership with the Malkangiri district health authority and LEPRA India, an NGO with extensive grassroots presence on health issues. The intervention aimed to increase the coverage of the Revised National Tuberculosis Control Program (RNTCP) in the district.

Given the geographical inaccessibility, huge physical distances between sparsely populated villages, and the social and cultural distances between the people and health providers, a composite package emphasizing inter- and intra-sectoral collaboration and community participation was developed to increase TB case detection and treatment completion.

Goals/objectives

The goals of the project were to:

- Increase TB case detection and access to TB services among difficult-to-reach populations.
- To develop community DOTS, using provider-friendly pictorial treatment cards for case-holding and monitoring.
- Decrease social distance between service providers and communities through culture and communication workshops.
- Develop a government–NGO interface for management of sputum collection, case detection, and supervision.

Target audiences

Primary audiences were difficult-to-reach tribal populations in Malkangiri district. Secondary audiences were health staff and community DOTS providers.

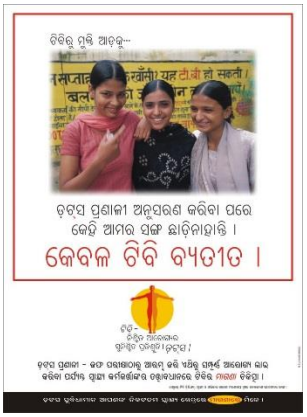
Process/strategies

The pillar of the intervention was the establishment of a corps of community DOTS providers in remote tribal areas with low literacy rates and limited access to health care. This involved developing appropriate communication and training materials to equip the NLDPs to understand TB as a public health problem in their area, to generate awareness about it at local level, to help symptomatic people access microscopy services and to supervise treatment of identified cases based on the principles of DOTS. As many as 505 non- and neo-literate volunteers were trained as DOT providers in the course of the intervention. They were trained to use a pictorial treatment card to chart patients' treatment. Due to the inaccessible places of habitation, it was not possible for the two senior treatment supervisors (STS) in Malkangiri to adequately supervise the community DPs. Consequently, TASs were identified to serve as a link between the government health system, community DPs, and patients. Four such TASs were appointed to cover the three blocks in which the intervention was implemented.

The distance between the microscopy center (MC) and the patient's villages made it difficult for them to give a sputum test for diagnosis. To address this problem SCCs were conceptualized and staffed either by a pharmacist or a local volunteer, whose main function was to dispense containers to symptomatic persons and prepare slides of the sputum samples to be sent to the nearest MC for examination. Ten such SCCs were started at strategic locations in the intervention blocs.

In addition to the involvement of tribal communities in RNTCP through training community DPs and through appointing TASs, two culture and communication workshops were held to sensitize health system staff to the special needs of tribal patients. LEPRA India and Asha Kiran, an NGO running a local hospital, were involved as partners to implement intervention activities (workshops, DOT, supportive supervision).

The intervention was designed to strengthen these areas through a four-pronged approach that stressed community participation and NGO involvement:



1. Access to directly observed treatment in tribal communities through training a large number of community DPs, including NLDPs, who were able to fill a specially designed pictorial treatment card. Local origin of these DPs should effectively overcome language barriers and distrust at the DP–patient level.

2. Extensive supportive supervision was provided by a new category of supervisory staff, the TAS. The TAS would be of local tribal origin. He would not hesitate to travel to even the remotest villages; he would belong to and be respected by local tribal communities, and would not have any language barriers. He was intended to function as an extension of the STS in difficult tribal areas. It was an important outcome of the intervention to obtain experiences with government NGO collaboration in a scenario where NGO staff (TAS) would collaborate directly with government health staff.

3. Access to diagnostic services through establishing SCCs at strategic points. The preferred location was a health sub-center with a pharmacist who could be trained to prepare the slide and send it to the MC. In some cases, local volunteers were trained if no sub-center was located near clusters of villages.

4. Improved provider communication to reduce misunderstanding and distrust between providers and tribal patients. In addition to the increased community participation implied in the above steps, this was sought to be brought about through holding “culture and communication sensitization workshops” for health staff.

Malkangiri Community DOTS Project Results

- Increase in awareness of TB and its treatment among remote villagers
- High appreciation for the TAS as a link between villagers and the health system
- High treatment adherence rates among patients treated by NLDPs
- Some improvement in patient–provider interaction

A web-based resource center was developed under the central TB Division website to facilitate sharing TB communication and education materials. Based on the collaborative efforts from Odisha state, there are now materials available in 17 languages.

Good practices

- **Adaptation of materials to local context**: Communication materials were developed for specific audience needs. This involved developing TB communication and training materials for NLDPs,

including a pictorial version of the standard TB treatment card. Most NLDPs found the card easy to use.

- **Expanded case detection/diagnosis through social mobilization:** The project established 10 new SCCs to provide easier access for villagers. Community volunteers and pharmacists were then trained to give containers to symptomatic persons, prepare slides of the sputum samples, and send them to the nearest MC for examination.
- **Expanded TB treatment through social mobilization:** The project recruited and trained over 500 NLDPs to provide treatment in hard-to-reach tribal areas. TASs provided supportive supervision to the NDLPs and acted as an extension of government STSs.
- **Strong media/community/health system linkages:** The establishment of NLDPs, TAS, and new SSCs forged new linkages between tribal populations and the health system. These linkages were strengthened by culture and communication workshops that helped to decrease the social distance between health staff and tribal populations.

12. Project AXSHYA ("TB Free")	
Donor: Global Fund (Round 9) **Implementing agency:** IUATLD (Int'l Union Against Tuberculosis and Lung Disease)	**Good practices:** • Adaptation of materials to local context • Extensive provider training/support • Strong/innovative partnerships • Strong media/community/health system linkages
Duration: 2010–2015 **Geography:** India	
Publication/Source: 1) *Project Axshya. A Civil Society Initiative to Strengthen TB Care and Control in India.* International Union Against TB and Lung Disease. No date. 2) Project Axshya. http://www.axshya-theunion.org/AxshyaSA.asp. Accessed October 28, 2013.	

Background

The Round 9 TB grant from the Global Fund to Fight AIDS, Tuberculosis and Malaria (The Global Fund) to India is among the largest and envisages a concerted response from government and civil society. The three principal recipients of the grant are the Government of India, The International Union Against Tuberculosis and Lung Disease (The Union), and World Vision India (WVI). Although the government focus is on drug-resistant TB, the other two seek to enhance RNTCP's reach and effectiveness, and strengthen the much-needed engagement of civil society in TB control. This landmark project aims to reach some 750 million people in 374 districts across 23 states of India by 2015—16 states managed by The Union, 2 by WVI, and 5 jointly.

Project Axshya is a civil society initiative led by The Union. It supports the RNTCP of India in expanding the program's reach and effectiveness through engagement with community-based providers.

Goals/objectives

The goal is to improve the quality of TB services and increase access to vulnerable groups like women and children, the marginalized and TB–HIV co-infected populations. It is being implemented in close collaboration with nine NGO partners

in a phased manner covering 90 districts across 15 states in Year 1 and expanding to 300 districts across 21 states by 2012.

The project aims to improve access to quality TB care and control through a partnership between government and civil society. It will support India's RNTCP to expand its reach, visibility, and effectiveness, and engage community-based providers to improve TB services, especially for women, children, marginalized, vulnerable, and TB–HIV co-infected populations. ACSM is a major focus.

Target audiences

The primary audience for the overall project is the general population, with a special focus on women, children, marginalized, vulnerable, and TB-HIV co-infected populations. For the mass media campaign, the target audience was men and women from ages 15 to 54 from rural and urban areas. Secondary audiences are health providers. Tertiary audiences are policymakers and parliamentarians.

Process/strategies

Project Axshya (meaning "TB-Free") focuses on ACSM activities through a national network of partner organizations that implement them in their respective states and districts through their own sub-networks of NGOs and CBOs. The Union is especially focusing on those who have the greatest difficulty in accessing TB services—women, children, marginalized, vulnerable, and TB-HIV co-infected populations. Of the 300 project districts that it will manage, over 200 comprise underperforming (with case notification rates of 50/100,000 or less), poor, geographically difficult, and predominantly tribal districts. The Union worked with partners in 90 districts in year 1, 240 districts in year 2, and 300 in year 3 of the five-year project, with Phase 1 running from April 2010 to March 2012. The project is complementing program efforts, engaging private providers in RNTCP schemes, improving access to diagnostics, committing to fight drug-resistant TB and TB-HIV at all levels, and enhancing civil society involvement in TB care and control.

Axshya's key project strategies and activities include the following:

- Empowering communities to enhance their participation in TB services
- Conducting needs-based and gender sensitive media campaigns
- Advocating with policymakers and parliamentarians
- Facilitating the involvement of all health care providers to increase the reach of TB services and ensure rational use of diagnostics and drugs
- Synergizing civil society's TB care and control services through partnerships
- Supporting and complementing RNTCP diagnostic and treatment services to increase access, especially in difficult and hard-to-reach areas
- Strengthening the state and district level ACSM capacity of program personnel
- Strengthening the linkages between TB and HIV services
- Empowering affected and vulnerable communities by facilitating platforms for TB care

In the first year, the overarching focus was on beginning a process to engage communities in TB care and control across the 90 districts, while building capacity of health care professionals, providing technical support, conducting research, and managing the challenging task of implementing the project through an array of partners and sub-partners. Over 900 NGOs have been sensitized on RNTCP schemes. In addition, over 100 partners have joined the Partnership for TB Care and Control, linking with the RNCTP and connecting stakeholders through national and state coordination committees. Rural health

care providers have been trained to refer people with TB symptoms for sputum examination and incentivised to serve as DOT providers. More than 9,000 health staff has been trained on IPC and behavior change to better understand their patients.

The project has worked through the Gaon Kalyan Samitis (Village Health, Sanitation and Nutrition Committees) around simple messages on identification of TB symptoms and sputum testing. More than 40,000 meetings have been held. Project Axshya also launched the Bulgam Bhai, or "Mr. Sputum" mass media campaign that aims to increase TB awareness. The project carried out research to examine why there was low health-seeking behavior with TB symptoms. People were using home remedies or unaware of sputum testing services. These findings were used to craft content for the campaign, which includes: TV, radio, print ads, and IPC toolkits, games, and street theater scripts. Mr. Sputum—who is a superhero—uses humor to remind people that they need to have their sputum tested if they have a cough for more than two weeks. The intended audience includes men and women from ages 15 to 54 from rural and urban areas.

The Union has worked to empower TB patients by developing an illustrated version of the Patient Charter for TB Care, which outlines the rights and responsibilities of people with TB. This is available in 19 languages spoken across the country and is being disseminated through TB forums and community meetings. It will be prominently displayed in health care facilities across the project districts. The project has given current and past TB patients a voice by establishing more than 200 district-level TB forums. These forums work with program managers to advocate for the resolution of service access issues.

The Union has also made efforts to address links that continue to sustain TB as a major challenge, such as the links with poverty and malnutrition, with diseases like diabetes and HIV, and with the use of tobacco.

Project AXSHYA Results

- Increase in civil society and private partner involvement in the RNTCP
- Establishment of sputum collection and transport mechanisms in difficult-to-reach areas
- Creation of TB forums at the district level
- Holding of over 100,000 community meetings

Good practices

- **Adaptation of materials to local context:** Prior to disseminating the Patient Charter for TB Care and Control, the project developed illustrated version with inputs from all partners. It was adapted for 19 different languages.
- **Extensive provider training/support:** The project has trained over 10,000 rural health providers on TB case detection and treatment. Over 9,000 health staff have been trained on IPC/C and behavior change.
- **Strong/innovative partnerships:** The project has engaged partners across sectors—government, NGOs, private doctors, technical agencies, affected communities, and the media. The success of the project hinges on coordination with partners and stakeholders. Several of the NGO partners are implementing activities through their own sub-networks and local partners.
- **Strong media/community/health system linkages**: The Mr. Sputum mass media campaign drives people to the health system if they suspect that they might have TB. Establishing TB forums has empowered TB patients to advocate for the resolution of health service access issues. Disseminating the Patient Charter for TB care through these TB forums and community meetings has made the health system more accountable to the needs of those it serves.

13. Operation Asha	
Donor: Central TB Division (CTD) **Implementing agency:** Operation Asha	**Good practices:** • Expanded TB treatment/care through social mobilization • Focus on sustainability • Innovative community channels
Duration: 2006–2007 **Geography:** India (New Delhi)	
Publication/Source: *Advocacy, Communication, and Social Mobilization for TB Control: Collection of Country Level Good Practices.* WHO. 2010.	

Background

Operation Asha (the Hindi word for "hope") initiated operations in 2006 to combat the spread of TB in India. It is the largest nonprofit TB treatment organization in India, operating centers in the slums that often can be reached only on foot.

TB spreads quickly among families living in urban slums, where many live in unhygienic, poorly ventilated shanties. Other problems that exacerbate the spread of TB include HIV infection, severe malnutrition, and recurrent infections, as well as a lack of understanding of TB symptoms and inadequate availability of treatment. The spread of TB is also aided by a deep-seated fear of death from the disease, which contributes to an unwillingness to be tested for it, as well as the stigma TB patients often face. Efforts to stem the spread of TB are hindered by a lack of access to DOT centers, which, even if they are accessible, are only open for a short time, usually during normal working hours. In addition, given the significant time, effort, and money needed to reach the centers and the dire economic circumstances most slum dwellers face, many patients prioritize buying food for their families over paying for transport to seek diagnosis or treatment.

Goals/objectives

Since its inception, Operation Asha has worked with the inhabitants of some of the poorest areas in India, such as the rag-pickers' slum, where dwellers sort through garbage and typically earn US$0.20–US$1 per day. The project worked to increase case detection, reduce social stigma, and ensure zero-default on treatment.

Target audiences

The primary audience was people living in urban slums.

Process/strategies

Operation Asha set out to recruit slum residents and successfully treated TB patients and private health care workers to act as DOT providers to increase case detection, reduce social stigma, and ensure zero-default on treatment. Former TB patients from the slums represent a potentially important force in reducing TB-related stigma, since their positive example can not only motivate TB suspects to seek diagnosis (in large part by showing that the disease need not be fatal), but also other former patients and community members to become DOT providers.

Furthermore, because the slum residents typically provide DOT directly from their homes or shops (which are located in the midst of the communities and, therefore, are accessible to TB patients for a large part of the day), they greatly enhance access to treatment for residents who need to work. For all centers, Operation Asha received drugs directly from the RNTCP and oversaw distribution and inventory. Treatment follow-up services were provided by local government clinics to which people were referred as needed.

Other activities included extensive community outreach by Operation Asha's trained counselors. They conducted home visits to families to provide TB education and referred suspects to diagnostic centers, as well as education sessions in schools, temples, religious places, weekly bazaars, community centers, and factories.

As the DOT centers did provide diagnostic services, TB suspects identified through these outreach efforts needed to be referred to a local clinic or hospital. Upon receiving a confirmed TB diagnosis, patients could choose whether to receive DOT at the clinic or at the nearest community-managed DOT center. Operation Asha, together with the slum community, also played an advocacy role in engaging local politicians to support funding and resources to establish more DOT centers in the community.

Operation Asha's counselors monitored each individual patient and provided details to the RNTCP in various weekly, monthly and quarterly reports. Patients were followed three times a week and reports document events that adversely affect treatment outcome, such as missed doses, defaults, transfer of patients to other DOT centers and other cities, deaths, and hospitalization if patients become ill. The final treatment outcome was recorded in government-operated clinics after the result of the final sputum microscopy sample.

Operation Asha Results

- Double the number of case notifications
- Decrease in treatment default rates

Good practices

- **Expanded TB treatment/care through social mobilization:** Slum dwellers and private providers were recruited as DOT providers. Treatment was also offered at over 160 community-managed DOT centers. Project counselors also monitored patients three times a week. This resulted in defaulter rates that dropped from 5 percent to 3 percent and case notification rates that doubled.
- **Focus on sustainability:** The project also supported the slum community to play an active advocacy role in engaging local politicians to support funding and resources to establish more DOT centers in the community.
- **Innovative community channels:** Extensive community outreach was carried out in homes, schools, temples, religious places, weekly bazaars, community centers, and factories.

14. BRAC	
Donor: Global Fund (2004–present) **Implementing agency:** BRAC	**Good practices:** • Expanded TB treatment/care through social mobilization • Extensive provider training/support • Focus on sustainability
Duration: 1984–ongoing **Geography:** Bangladesh	

	• Participatory processes • Strong media/community/health system linkages
Publication/Source: 1) BRAC's Tuberculosis Program: Pioneering DOTS Treatment for TB in Rural Bangladesh. May, M., Rhatigan, J. and Cas, R. *Cases in Global Health Delivery*. Harvard Business Publishing. 2011. 2) *Community involvement in tuberculosis care and prevention: Towards partnerships for health.* Guiding principles and recommendations based on a WHO review. WHO. 2008. 3) *Community contribution to TB care: An Asian perspective*. WHO. 2002.	

Background

In Bangladesh, people suspected of having TB identified in general clinics are referred to TB DOTS centers, where staff administer facility-based directly observed treatment. Treatment interruption rates in these areas are high, since people with TB are more difficult to trace and the population is more mobile. In rural areas, effective TB control relies on community participation. The NTP started collaborating with NGOs one year after DOTS was introduced based on the following principles: mutual respect and trust; commitment to following national guidelines; pooling resources to maximize the use of partner expertise and to make the program cost-effective; and periodic review of program performance.

BRAC is a large community development organization focused on empowering the poor. BRAC has become very well known for its program that provides rural credit and training to underprivileged rural women. BRAC also offers education and health programs, implemented largely by community health workers. These health workers receive intensive training and are closely monitored by BRAC community health organizers. BRAC has been treating TB in small areas since 1984 and serves 67 percent of the population. BRAC originally focused on rural areas, but has more recently been able to expand into some urban areas, thanks to support that the NTP has received from the Global Fund to Fight AIDS, Tuberculosis, and Malaria.

Goals/objectives

The goal of BRAC's TB program is to achieve and sustain at least 70 percent case detection and 85 percent treatment success among smear-positive TB cases under DOTS.

Target audiences

The primary audience is the rural and urban poor and TB patients. Community health workers are the secondary audience.

Process/strategies

BRAC establishes its own health centers and also uses the Participation, Interaction, and Mobilization (PIM) Process, which views social empowerment as the critical engine of behavior change. PIM trains village woman to be community health workers, or shastho shebikas, thereby promoting active community participation in disease management by civil society organizations. Shastho shebikas are chosen from "village organizations"—BRAC female micro-credit schemes containing 40 to 50 members per village. The village council proposes two or three of the village organization members as possible shastho shebikas, and BRAC selects one after talking to their family members. Each shastho shebika

receives seven weeks of training and is responsible for visiting about 330 households every month to provide primary health care services,

Shastho shebikas form the core of BRAC's TB control effort by providing DOTS and catalyzing community members to participate in creating awareness, mobilization, household level visits, and stigma reduction. Ultimately the approach is aimed at transferring ownership and agency of TB disease management from a smaller group of health managers at various levels to include civil society as a whole.

Shastho shebikas are allowed to sell TB medicines at an agreed price and are motivated by performance-based incentives. They receive five days of training and monthly refresher courses to serve as DOTS providers. They usually spend about two hours daily working as health volunteers. A shastho karmi supervises every 10 shastho shebikas. Village leaders know shastho shebikas and refer people suspected of having TB to them. Whenever a new case is diagnosed, the person with TB pays 200 taka (about US$3) to the shastho shebika as a pledge.

The Global Fund funds pay for the incentives of the shastho shebikas (150 taka) so that the person with TB can get back the entire sum of money upon completion of treatment. People with TB go daily to the shastho shebika's home to receive DOTS. If a person with TB does not turn up, the shastho shebika must to go to his or her home. If a person with TB still has problems in adhering to treatment, shastho shebikas have to report this to the village authority, which will contact the person with TB to encourage them to continue treatment. BRAC staff members also visit the homes of people with TB at least monthly during the intensive and continuation phases; the regularity of this exercise depends on the availability of staff in that district.

When a shastho shebika encounters a person suspected of having TB, she provides a sputum container, which is then taken to one of BRAC's smearing centers a few kilometers away. BRAC staff members visit the smearing centers once a week, fixing slides and taking them to a laboratory for sputum smear examination. If the examination is positive, BRAC contacts the shastho shebikas and provides a weekly dose of medicines for the intensive phase and several months' supply for the continuation phase.

BRAC has also established TB clubs, made up of people who have had TB. TB club members are usually not directly observed treatment providers, but they help to identify people suspected of having TB in their community and workplace. BRAC occasionally holds meetings with TB club members to discuss TB symptoms and how to recognize people suspected of having TB.

BRAC TB Program Results

- Case detection rate higher than the national rate
- Treatment success rate of 93%

Good practices

- **Expanded TB treatment/care through social mobilization:** BRAC mobilized existing shastho shebikas to serve as DOTS providers in their communities. This greatly expanded access to treatment in rural areas. The shastho shebikas are highly accepted, since they come from the same communities as the TB patients. Adherence is encouraged by requiring TB patients to pay a deposit, which they receive back when they complete treatment. BRAC staff visit patients monthly. On average, patients receive six to eight visits during the intensive phase of treatment.

- **Extensive provider training/support:** Shastho shebikas receive seven weeks of initial training when they become community health workers. TB training lasts five days and is followed up by monthly refreshers. BRAC and the government provide very intensive, multi-level supervision to the shastho shebikas, which is reinforced by systematic checks conducted by BRAC's Monitoring and Internal Audit Department, as well as its Research and Evaluation Department.
- **Focus on sustainability:** BRAC's TB services were integrated into an existing community program whereby village organizations selected shastho shebikas to be trained as community health workers. BRAC finances its own training and human resources, thanks to the micro-credit and other social enterprise schemes, making their program more sustainable in the long run.
- **Participatory processes:** The whole BRAC model is rooted in the idea of empowerment and collective action. Villages establish micro-credit schemes, and select members of these organizations to be shastho shebikas. These women provide health education and basic health care services to their own communities.
- **Strong media/community/health system linkages:** BRAC's shastho shebikas have established important links between rural communities, BRAC health centers, and the NTP. They provide much-needed education on TB and other important health topics, and refer villagers for diagnosis and treatment. TB clubs are another link between the community and health care centers.

15. Damien Foundation	
Donor: Global Fund **Implementing agency:** Damien Foundation	**Good practices:** • Addressed stigma • Expanded case detection/diagnosis through social mobilization • Expanded TB treatment/care through social mobilization • Strong media/community/health system linkages
Duration: 1991–ongoing **Geography:** Bangladesh	
Publication/Source: 1) *Technical Assistance Experience from Bangladesh.* Ali, S. et al. Power point presentation. No date. 2) Turning liabilities into resources: informal village doctors and tuberculosis control in Bangladesh. Salim, MA. et al. *Bulletin of the World Health Organization*. June 2006. 84 (6). 3) *Community involvement in tuberculosis care and prevention: towards partnerships for health: guiding principles and recommendations based on a WHO review.* WHO. 2008.	

Background

The Damien Foundation has been treating TB since 1991; a memorandum of understanding was signed with the Ministry of Health in 1994. Bangladesh is considered as a model for government and NGO partnership in TB control. With 75 percent of the population of Bangladesh living in rural areas, village doctors provide most of the outpatient health care in the country. Poor quality of their services, delays in TB diagnosis, and irrational use of drugs have all hindered TB control. The Damien Foundation recognized the potential of these "non-doctors," who are well accepted by people in rural areas, to improve access to quality TB care in villages. The Damien Foundation supports implementation of TB control activities in 13 districts, five medical colleges, and 12 jails in Dhaka covering 27 million people.

Goals/objectives

The Damien Foundation works to recruit former TB patients, village doctors, and local leaders to establish and carry out community-based DOT.

Target audiences

The primary audience is people living in rural areas and TB patients. Village doctors are the secondary audience.

Process/strategies

The Damien Foundation uses the following strategies:

- Social mobilization through cured TB patients
- Engaging village doctors, cured patients, and local elites to administer DOTS

The Damien Foundation uses the existing function of village doctors as DOTS supporters. They usually earn a living by selling medicine, but they do not charge consultancy fees and are often a villager's first contact when they seek care. They are laypeople with six months of government training. One village doctor covers a population of about 5,000. Since 1998, over 12,000 village doctors have been trained.

One in five village doctors becomes a fixed DOTS provider. Fixed DOTS providers identify people suspected of having TB, who are given sputum cups that they take to diagnostic centers themselves. Microscopy centers are located at government-run upazila (subdistrict) health centers or Damien Foundation clinics. Fixed DOTS providers are responsible for following up sputum examinations and getting medicines from the health centers. People with TB are expected to come to the upazila health center every two weeks. Damien Foundation staff members ensure that treatment is not interrupted. If a person with TB misses a second visit to the health center, Damien Foundation staff members visit the person with TB at home, accompanied by the fixed directly observed treatment provider.

The work allows village doctors to gain importance and provide a helpful service in their communities, and they receive regular refresher training from the Damien Foundation. In addition, reorientation sessions for health staff on TB protocols are conducted along with community awareness sessions. The main challenge of their involvement is maintaining the standard of care and ensuring continuous supervision.

People who have had TB are encouraged to join TB clubs. After forming a TB club, members receive annual refresher training. Their responsibility is to refer people suspected of having TB for a sputum check, and they often accompany them. In some cases they may also become directly observed treatment providers. For management of complicated cases, the Damien Foundation runs district. Otherwise, all people with TB are on community-based DOTS and are not given the option of being treated at the hospital. The number of women suspected of having TB who go for a sputum check has increased significantly in recent years, but most women still need to ask permission from family members to go to a diagnostic center.

Damien Foundation Program Results

- Higher sputum-spear positive rates for cases referred by village doctors than for cases referred by other health staff
- Treatment success rate of 90%
- Perceived decline in stigma

The project reported that stigma has declined significantly with the introduction of community-based care. People were less afraid to seek treatment because they knew that the disease was curable and the treatment was free of user charges.

Good practices

- **Addressed stigma:** Stigma was addressed through utilizing former TB patients to carry out DOTS within their communities. The Damien Foundation considered former TB patients to be crucial to stigma reduction and the success of the DOTS strategy.
- **Expanded case detection/diagnosis through social mobilization:** The Damien Foundation recruited village doctors to identify people suspected of having TB, take sputum cups to diagnostic centers, and then follow up on the sputum examinations. TB club members also helped to identify new TB cases.
- **Expanded TB treatment/care through social mobilization:** Over 12,000 village doctors were trained to be DOTS supporters and provide treatment free of charge in their communities.
- **Strong media/community/health system linkages**: Through the use of village doctors, the Damien Foundation selected people who lived within and have an established relationship with communities to form the key link between the community and the formal health care system. TB clubs form additional links by referring community members to health services.

IV. Conclusion and Additional SBCC Resources

Despite widespread access to treatment and care, TB remains a major problem in India, with over a million cases detected a year and an estimated 40 percent of the population infected with TB bacteria. Although there have been several noteworthy TB control programs implemented in different parts of India, they have focused largely on engaging communities in TB control and care, and there has been no national TB communication campaign to date. There is a need for more coordinated, large-scale ACSM efforts that go beyond treatment and care to include systematic communication planning and a broader mix of media channels to reduce TB-related stigma and educate the public about transmission, symptoms, and treatment. Large-scale ACSM efforts implemented in other Asian countries and other regions have yielded several good practices that could potentially be used in India.

- **SBCC Toolkit (C-Change Project)**: This toolkit includes products and online resources to support training and courses in SBCC. It includes an SBCC Framework, Capacity Assessment Tool, and bulletins on specific SBCC topics: http://c-changeprogram.org/resources/sbcc-toolkit

- **Social and Behavior Change Communication Training for Information, Education and Communication Officers (IHBP):** This is a one-week training for information, education, and communication officers in India on designing, implementing, and evaluating SBCC programs and campaigns.
  http://www.ihbp.org//content/sbcc-toolkit

- **IHBP Toolkit:** This toolkit was designed as a job aid for information, education, and communication officers in India to provide practical tools and templates to assist them in designing, implementing, and evaluating SBCC programs and campaigns.

- **SBCC for Frontline Health Care Workers (C-Change Project):** This is a learning package for use in face-to-face workshops with nurses, community health extension workers, and HIV counselors on SBCC and interpersonal communication (IPC).

http://www.c-changeprogram.org/resources/sbcc-frontline-health-care-workers

- **Advocacy, Communication & Social Mobilization (ACSM) for Tuberculosis Control: A Handbook for Country Programmes. World Health Organization and the Stop TB Partnership.** This Handbook is a guide to support the design, implementation, monitoring, and evaluation of effective ACSM activities at the national level. It describes each step, illustrating them with case studies, and provides concrete tools, such as a creative brief template and a focus group discussion guide: http://www.stoptb.org/assets/documents/resources/publications/acsm/ACSM_Handbook.pdf

- **Advocacy, Communication, and Social Mobilization to Fight TB: A 10-Year Framework for Action. World Health Organization and the Stop TB Partnership.** This document is the workplan of the Stop TB Partnerships ACSM Workgroup. It provides an excellent summary of how ACSM can support TB programs, along with summaries of lessons learned, diagnostic and planning tools, and communication resources. http://www.stoptb.org/assets/documents/resources/publications/acsm/TB-ADVOCACY.pdf

- **The New P–Process: Steps in Strategic Communication:** This brochure summarizes the strategic communication planning framework developed by The Johns Hopkins University Center for Communication Programs. http://www.–.org/hcp/pubs/tools/P-Process.pdf

- **Leadership in Strategic Health Communication Workshop:** Every year The Johns Hopkins University Center for Communication Programs holds a three-week workshop in the United States to train SBCC professionals in the steps of designing effective health communication and advocacy strategies. http://www.jhuccp.org/content/leadership-strategic-health-communication-workshop

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